Occupational Therapy Clinical Guide for Activities of Daily Living & Functional Cognition in Adult Acute Care

Provincial Occupational Therapy Practice Council

Allied Health Professional Practice and Education

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Contents

Purpose and Background

The purpose of this guide is to support Alberta Health Services (AHS) occupational therapists (OTs) in providing high quality, evidence informed, efficient interventions for two core clinical activities - Activities of Daily Living (ADL) and Functional Cognition in adult acute care settings. Core Clinical Activities (CCAs) are "*commonly delivered, evidence-informed interventions, essential to client and family centred care, and appropriate for the practice of a discipline"* [AHS, 2021]. **ADLs and Functional Cognition are two of the most frequent and most impactful area of OT intervention. However, the list of other CCAs is extensive and OT practice is not limited to these two.**

This Clinical Guide is a support document for the OT Service Standard - Acute Care Adult (ADL & Functional Cognition) and Prioritization Tool (AHS, 2021), which assists operational leaders, practice leaders and OTs in defining expectations, efficiencies and priorities. The Guide itself specifically endeavors to help OTs apply the standard, articulate their role, and integrate best practices into their daily work. It supports front line OTs, as well as OT clinical and practice leaders, in answering the following questions:

- *What are current best practice recommendations in the areas of ADL and Functional Cognition?*
- *How do I integrate these recommendations into my daily practice?*
- *Why is it important to identify the unique and valuable role of OT in acute care?*
- *How do I promote and advocate for occupation-centred practice?*

The Clinical Guide builds upon current clinical competencies, support systems and established practice processes but also to challenge OTs to incorporate current and emerging evidence that emphasizes the valuable and unique role of Occupational Therapy. Literature review, examination of international and national practice trends and consultation with OT practice leads and subject matter experts guided the development of this document.

See Insite for more information about Allied Health Standardized Services & Approaches.

Evidence for ADL and Functional Cognition in Acute Care

Self-care has long been an established core component of OT practice and there is recent research more closely examining the relationship between ADL, functional status, and hospital readmission rates. A study of over 22,000 community dwelling seniors (Greysen et al., 2015) and another of over 3000 patients who sustained an acute myocardial infarction (Dodson et al., 2019) established that ADL dependence and decreased functional mobility were associated with increased 30-day acute care hospital readmission. Readmission is also a concern in Alberta with AHS reporting a total acute care readmission rate of 13.9% (AHS Planning & Performance, 2020). A direct association between occupational therapy and readmission rates was demonstrated in Rogers et al.'s 2016 study where, out of 19 categories, only OT was associated with reduced readmission rates. A recent systematic review also concluded there is moderate evidence that an increase in OT, particularly to support transitional care interventions, reduced hospital readmissions (Lockwood & Porter, 2022).

> *"OT is the only service category where there is a statistically significant relationship between increased spending and lower readmission rates across all three medical conditions [heart failure, pneumonia, acute myocardial infarction]."*
> Rogers et al., 2016, p. 668.

In 2020, Roberts et al. published a compelling policy perspective article recommending practice areas where OTs could make unique contributions to reduced readmissions. They advocated for a shift from volume-based metrics to high values practice areas stating, "Occupational therapy places a unique and immediate focus on patients' functional and social needs, which can be important drivers of readmissions if they are not addressed." *(*Roberts, et al., 2020, Introduction*).* Chief amongst high value OT interventions were *ADLs, IADLs, and Functional Cognition.*

Occupational Therapists in acute care have long been involved in assessment of cognitive deficits and their impact on activities of daily living, frequently receiving referrals for standardized screening, ADL assessment or 'assess for discharge'. In a 2021 AHS survey of practices around cognitive screening, OTs frequently commented that their interprofessional teams did not have sufficient knowledge of what was involved in an OT Cognitive Assessment. When assessing occupational performance in acute care, instead administering a stand-alone standardized cognitive screen, OTs should address *Functional Cognition**. The emergence of the term *Functional Cognition* articulates the unique perspective of OT in this area and provides greater role clarity. Functional Cognitive assessments do not quantify specific cognitive skills but look at an *individuals' capacity to perform essential tasks given ALL their abilities including use of strategies, habits and routines and environmental resources.* This promotes the integration of all occupational participation components to provide recommendations for post-acute care that are more relevant than simply listing potential deficits in a specific cognitive domain.

*FUNCTIONAL COGNITION is defined as the *"Observable performance of everyday activities resulting from a dynamic interaction between motor abilities, activity demands and the task environment, which is guided by cognitive abilities."* (Wesson, 2016 in Wesson and Giles, 2019, p. 8).

Occupation-Centered Practice in Acute Care

There are unique practice considerations for OT in acute care including:

- Medical complexity of patients
- Fluctuating functional and cognitive status (including high prevalence of delirium)
- Timing of OT interventions
- Time and system-level constraints
- Physical environment

To meet these challenges, Smith-Gabai and Holm (2017) note OTs rely heavily on occupation-based activities and may simultaneously provide screening, evaluation, intervention and discharge planning.

Occupation-centred practice guides professional reasoning and is reflected through the implementation of occupation-based and occupation-focused interventions (Fisher, 2013).
It is important for Occupational Therapists to consider not only *what* interventions have a large impact in acute care (ADL and Functional Cognition) but also *how* they relate to occupational goals. While increased independence is often seen as the ultimate end goal of OT interventions in acute care, **occupation-based interventions can also be the means of achieving increased occupational participation in a variety of areas.** While an individual's goal may not be full independence (i.e., external supports are in place for self-care at home), occupation-based interventions such as participation in morning self-care routine while in hospital can serve to improve balance, endurance, cognitive skills such as initiation and problem-solving, as well as promote a sense of autonomy.

> *In acute care, occupational therapists should utilize their occupational lens to provide meaningful interventions that will contribute to higher quality of care, improved patient outcomes and reduced readmissions.*
> Roberts et al., 2020.

As part of the Choosing Wisely Initiative, the American Occupational Therapy Association published 'Ten things patients and providers should question' (2018). This list includes several recommendations about non-purposeful activity in general with recommendation number five specifically stating: *"Don't provide cognitive-based interventions (e.g., paper-and-pencil tasks, table-top tasks, cognitive training software) without direct application to occupational performance. The use of cognitive-based interventions not based on occupational performance will result in suboptimal patient outcomes."* Sources for this recommendation include systematic reviews of literature in stroke and dementia (see source document for secondary reference).

> *Occupation-based interventions, selected by the client, can result in increased client engagement, increase motivation and satisfaction from therapists, contribute toward enhanced professional identity and lead to improved representation and understanding of the profession. (*Ford et al., 2021; Murray et al., 2021*)*

Standardized Cognitive Screens & Performance Based Assessments

Cognitive Screens

The AHS Cognitive Screening webpage identifies six global cognitive screens that are evidence based, accessible, and appropriate for a variety of populations. There is value in having common, easily recognized screens across AHS, however, OTs may utilize other screens that target specific domains, populations or purposes.

Appropriate uses of *Cognitive Screening tools* include:

- ✓ Triage referrals
- ✓ Monitor known impairments
- ✓ Identify appropriateness for specific interventions or programs (including medication funding)
- ✓ Identify need for more in-depth assessment (i.e., diagnostic assessment by a physician or psychologist; communication assessment by SLP)
- ✓ Identify need for functional cognitive assessment

In acute care, considerations such as infection precautions, crowded environments and medical acuity can significantly impact tool selection and efficacy. OTs are encouraged to consider if acute care is the best environment to assess functional cognitive abilities or if referral to a community or post-acute provider is more appropriate.

In addition to the above uses, OTs may utilize standardized cognitive screens as one element of a Functional Cognitive assessment however, when no occupational performance issues related to cognition are identified, screens can be administered by a variety of health care providers. The AHS Guide to Cognitive Screening provides more details on general cognitive screening as performed by a variety of health care providers as well as detailed administration and scoring guides for identified tools.

A recent article in the American Journal of Occupational Therapy entitled '*Screening tools: They're So Quick! What's the issue?'* states that while screens can be quick, low cost and easy to use they are commonly misused (Boone, Henderson & Dunn, 2022). They compare screening tools to a vehicle's check-engine light:

> *"Both a screening tool and a check-engine light serve as brief, easy-to-implement fail-safes to determine when a problem might exist. When a check-engine light comes on, a car requires further expert opinion in the form of a mechanic who confirms the issue (i.e., formal evaluation) and then makes a plan to address the issue (i.e., treatment plan). A person would never trust their check-engine light alone to diagnose a problem with their car or have a mechanic begin working on it without first confirming that a problem exists."* (Boone, Henderson, & Dunn, 2022, p. 3).

Cognitive assessment tools are in depth tools that provide more detailed information about performance-based skills or specific cognitive domains. They are administered by professionals with some expertise in cognitive assessment, such as occupational therapists, and help answer specific

questions such as *"What kind of problem? What is the degree of the problem? What is the impact of the problem in a specific context?"*

Standardized measures can be an important component in functional cognitive assessments. Acute care OTs regularly engage in structured observation of occupational activities or attempt to simulate post-discharge activities, however, Giles et al., (2020) suggest this 'naturalistic' approach is not well understood outside of our profession and advocates for the systematic use of performance-based assessments. This type of assessment provides insight into cognitive abilities/deficits through the lens of performance of a meaningful occupational activity and considers the influence of context, familiarity, environment and learned strategies or habits. It also encourages standardized administration, cuing, scoring and interpretation.

> "Given the value placed on evaluating and treating impaired functional cognition to prevent poor post-discharge outcomes, it is essential that [OTs] develop, validate, and systematically use performance-based assessments of functional cognition."
>
> (Giles et al., 2020, p. 2.)

Because not all standardized tools are validated in acute populations nor even practical given person and environmental considerations, it is important to consider the following questions prior to administration of a standardized tool:

Is the individual stable from a medical viewpoint*?* Screen for potentially reversible causes of cognitive impairment such as delirium or substance withdrawal and consider impact of acute illness, medications, pain, fatigue, or psycho-social stressors associated with a hospital stay.

What is the purpose/reason for referral? What is the client's occupational profile *(what do they need or want to do?) Is there an occupational participation issue?*

- When occupational participation issues are established, consider whether a screening tool is needed or if proceeding directly to a performance- based assessment is more appropriate.
- Check collateral history including Netcare or Connect Care if available to determine if previous evaluation or standardized assessments have taken place.
- Referrals for screens to 'establish baseline' are a lower priority or could be done by another provider (i.e. physician, resident, student intern).
- Referrals to 'monitor change over time'. Consider tool sensitivity - screening tools in isolation are not good indicators of disease progression. Particularly in acute care, test scores can be heavily influenced by medical status, fatigue, medications, stress, environment, lack of vision, hearing or communication supports and may not be comparable to scores at other times.

Does the potential issue impact discharge? If not, consider if acute care is the best place to evaluate function. If community resources are limited and acute care is the only accessible option, then it may be indicated to administer the assessment in acute care with careful consideration of impact of the setting.

Is standardized testing appropriate considering medical, cultural, education, and social context? Consider tools designed for this specific context (i.e. RUDAS), whether a translator is beneficial, or if performance-based testing or structured observation of occupational activity is appropriate.

Examples of Cognitive Screens/Assessments

Based in part on: *Cognition, Cognitive Rehabilitation and Occupational Performance – Appendix B. (AOTA, 2019).* This table is not all-inclusive, nor does it include domain specific tools such as the FAB or EXIT Interview.

TYPE	***DESCRIPTION***	***EXAMPLES***
Interviews	Provide background information to create occupational profile and collaborate on goals.	COPM Activity Card Sort
Screening Tools	Generalized screen to identify presence of deficits and need for further performance-based assessment.	***Saint Louis University Mental Status (SLUMS)*** ***Rowland Universal Dementia Assessment Scale (RUDAS)*** ***Addenbrooke Cognitive Evaluation (ACE III)*** ***Oxford Cognitive Screen (OCS)*** ***Cog-Log*** ***Screen for Cognitive Impairment in Psychiatry (SCIP)*** Montreal Cognitive Assessment (MoCA) Butt Non-Verbal Reasoning Test (BNVR) Allen Cognitive Levels Screen-5 (ACLS) Trail Making Test A & B
Performance Based tests of Functional Cognition	Identify occupational performance issues related to cognitive deficits.	***Kettle Test*** ***Kohlman Evaluation of Living Skills (KELS)*** ***Executive Function Performance Test (EFPT)*** ***Executive Function Route Finding Test (EFRT)*** ***Multiple Errands Test*** Performance Assessment of Self-care Skills (PASS) Weekly Calendar Planning Activity Routine Task Inventory Assessment of Motor and Process Skills (AMPS)
Specific Cognitive Functions (i.e. memory, attention) AND client factors	More detail on occupational performance issues and inform intervention plan.	Independent Living Scales (ILS) Behavioral Assessment of the Dysexecutive Syndrome (BADS) Loewenstein Occupational Therapy Cognitive Assessment (LOTCA) Contextual Memory Test *original no longer available – web version being piloted free of charge Rivermead Behavioural Memory Test Test of Everyday Attention (TEA)

****Bold/Italicized items** are available free of charge OR AHS holds license for.

Additional Resources for Cognitive Screening & Assessment Tools

- Vancouver Coastal Health Cognitive Assessment Inventory 2018
- Rehabilitation Measures Database
- Cognitive Screening and Assessments (Multi-context approach website)
- Functional Cognitive Assessment Website (Multi-context approach website)
- Assessments | WUSTL Occupational Therapy
- AHS Cognitive Screening
- Strokengine Assessments

Cognitive Rehabilitation

Interventions targeting functional cognition may take include direct or indirect strategies, as well as cognitive stimulation for individuals with lower levels of participation.

COGNITIVE STIMULATION

Acute care OTs frequently engage in cognitive stimulation and early cognitive rehabilitation for clients with lower levels of participation, particularly in the context of delirium prevention. The *AHS Rehabilitation Approach to Delirium Prevention and Cognitive Stimulation in Critical Care* provides suggestions for cognitive stimulation for individuals ranging from those who only respond to intense repeated stimulation (sensory stimulation to promote wakefulness; reorientation; clear communication) to those with normal wakefulness (use of environmental controls; developing and filling in notes, journals, schedule planners; functional cognitive activities).

DIRECT STRATEGIES

a) *Task or Habit Training* attempts to circumvent cognitive deficits by learning a routine and approaching the same task in the same way using the same technique. It can be useful for individuals with more significant impairments who may not be able to modify behavior or develop goals. The skills are not typically transferrable to a different occupation and. (example: Morning care routine with an individual with an acquired brain injury).

b) *Strategy Training* is intended to help individuals learn strategies to overcome challenges and are meant to be applicable or transferable to a variety of occupations. This is most successful with individuals who have some awareness of their challenges. Two categories of strategy training are:

- Metacognitive Strategies are global strategies that can be used in any context (i.e., rehearsing, problem solving, self-questioning)
- Domain specific Strategies compensate for specific limitations that impact occupations across similar tasks (i.e., note taking for memory)

For examples of cognitive treatment plans, see AOTA article on Cognition, Cognitive Rehab & Occupational Performance (2019): Appendix A: Cognition Case Examples and Choosing Wisely Recommendation #5.

c) *Domain specific remediation* includes activities targeting specific cognitive deficits in the absence of an occupational focus. Examples include paper and pencil or computer-based tasks. **There is limited evidence that this type of training improves occupational participation,** as it does not typically generalize.

INDIRECT STRATEGIES

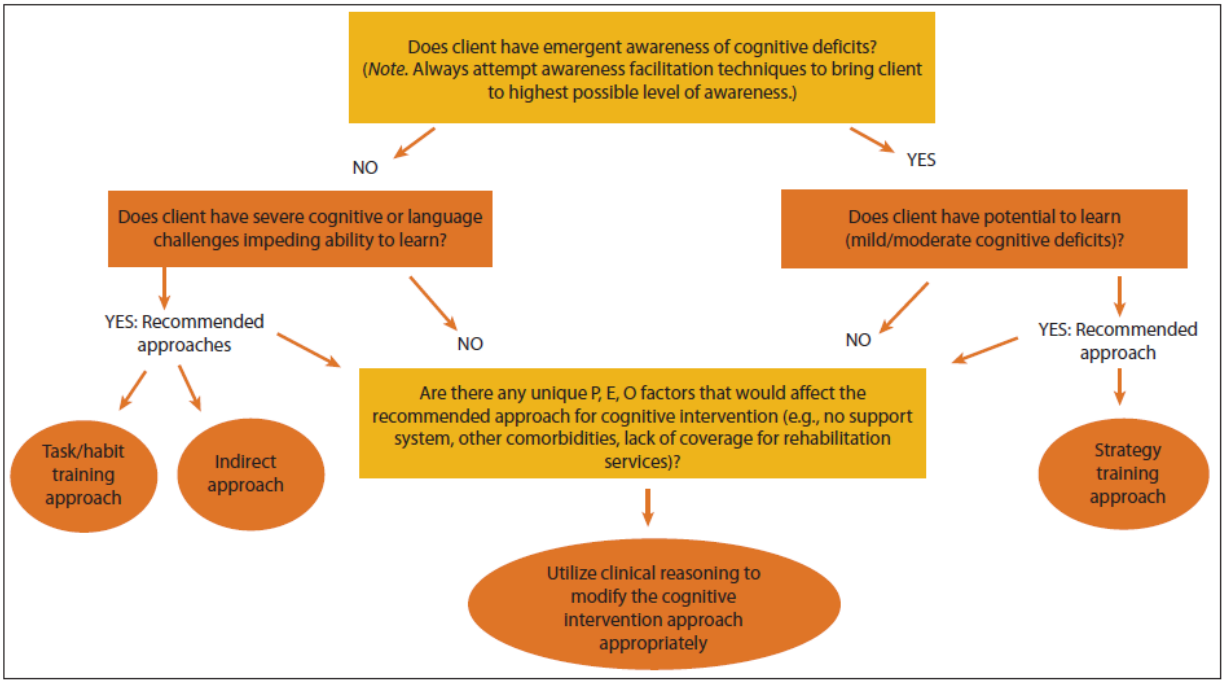
These strategies are useful when the individual is reliant on an external source or support, such as when living with dementia. Examples include *task simplification, environmental modification and care partner education*.

WHICH APPROACH IS BEST FOR MY CLIENT?

Selection of an appropriate intervention is grounded in clinical reasoning based on person, environment and occupation factors (Barco, Gillen, & Wolf 2020).

- *Personal factors* might include individual's age, education, premorbid function, level of awareness/insight and ability to learn
- *Environmental factors* include current and future environment, personal supports, and financial resources
- *Occupational factors* include whether the task is procedure or novel

FIGURE 17.2. Frames of reference: Decision tree for choosing a cognitive intervention approach.



Note. P = person; E = environment; O = occupation.

From: Barco, P.P., Gillen, G., & Wolf, T.J. (2020). Intervention selection: Learning and concepts of transfer. In Wolf, T.J., Edwards, D.F. & Giles, G.M. (Eds) Functional cognition and occupational therapy: A practical approach to treating individuals with cognitive loss. (p. 185).

Treatment Ideas for Occupation-Based Activities

Occupation-based activities can serve not only as the goal or end result (*i.e., increased independence in ADLs*) but also as the means to achieve goals (*i.e., Morning self-care to improve sequencing, problem solving, endurance, balance, weakness that impedes occupational participation*). Here are some practical ideas for occupation-centred treatments:

- Encourage self-care routines including planning and retrieving of supplies. Include less frequently performed tasks such as cleaning eyewear, braiding hair, or applying cream. Advocate for personal hygiene supplies (personal and hospital supplied)
- Incorporate mobility aids into functional mobility tasks such as opening doors/closets, pulling out a chair, making a bed, taking an elevator
- Incorporate functional mobility, mobility aides and wayfinding off the unit:
    - Browse the facility gift shop, cafeteria, food court. Practice information seeking with Information desk or other staff
    - Go to facility chapel or common space where music/entertainment maybe occurring.
    - Mobility aid use outside (doors, ramps, curbs, gravel, grass, snow, etc.)
    - As appropriate passes to i.e., local grocery story, library
    - As appropriate, use of public transportation – taking the bus, calling a taxi
- Fill out menus, day planner or white boards
- Identify relevant material on unit bulletin boards/white boards (*i.e., Who is your nurse today? What is the name of the manager? How many beds are there on the unit?)*
- Use mobile device to find relevant information such as personal contacts or weather
- Use newspaper or mobile device to find information about meaningful occupations (i.e., Sports team standings, maps/routes, store hours)
- Use leisure occupations as a treatment intervention
- Build occupational kits for activities such as housecleaning, office work, grocery shopping, community mobility/transportation and many others (see text box for websites)

OCCUPATIONAL KIT RESOURCES

Occupation-Based Kits | College of Health (utah.edu)

Occupation Kits | WUSTL Occupational Therapy

Functional Therapy Activities (private website – free and items for purchase)

Grocery Shelf Main (functionaltherapyactivities.com)

Occupation-based Groups **-** May include meal planning and preparation; baking and teas; leisure, hobby and crafts; gardening; current events; community access; etc.

AOTA's Choosing Wisely initiative recommends compiling Functional Cognitive Toolkits with the following elements:

- **Practical community access materials -** Maps of your facility, neighborhood, and city; Information on support groups and community centers; Schedules for facility or local community activities

- **Supplies for personal organization and work -** Templates for lists and planning; Calendars and planners; Office supplies such as pencils, pens, sticky notes, poster board; White boards and dry erase markers
- **Kitchen and household items –** Cookbooks, Cooking utensils, pots, pans, bowls, timer; Cleaning supplies; Food items such as cartons, boxes, bags
- **A handbook for accessing useful computer programs, apps, and websites -** Transit schedule and ridesharing apps; Online menus and meal planning resources; Budgeting and money management tools; Instructions for smartphone calendar, alarm, and app management

Resources for Cognitive Rehabilitation

- *Functional cognition and occupational therapy: A practical approach to treating individuals with cognitive loss.* Wolf, T.J., Edwards, D.F. & Giles, G.M. (Eds). **Available from AHS library or AOTA*
- ACRM Cognitive Rehabilitation Manual
- Treatment-resources (Multi-context approach website)

Practice Process in Acute Care

Occupation is the core domain for concern for occupational therapy practice (Townsend & Polatajko, 2013). Occupational therapy services should include identification of occupational participation strengths and challenges related to person, environment, and occupation. A strong focus of OT practice in acute care is to coordinate a safe, efficient, and timely discharge and services may include triage, screening, assessment, treatment, education, consultation, and referral. The OT addresses ADLs and Functional Cognition as they pertain to client- and family-centred goals, required supports, risk identification and mitigation, successful facilitation of discharge or transition planning, and prevention of future hospital admissions (Jonsson et al., 2017). The OT role in acute care often includes advocacy for occupational participation and discharge or transition planning.

Occupational therapists apply conceptual models such as the Person-Environment-Occupation (PEO) model or the Canadian Model of Occupational Performance and Engagement (CMOP-E) when addressing ADLs and Functional Cognition. The interplay between all person components, discharge location environment and availability of supports, and the client's meaningful occupations, are considered throughout the OT practice process.

Central to the OT practice process, is building and sustaining relationships with the client, family and treatment team. A collaborative process is applied to identify and address occupational participation issues, contributing to positive outcomes. Throughout the interactions with the client, family and treatment team, the occupational therapist is considering the contexts and applying clinical reasoning to guide OT interventions. Clients do not progress through the occupational therapy process in a linear fashion and at times domains in the practice process need to be revisited to meet their needs. Interventions are occupation-focused throughout the process.

Occupational therapists are encouraged to learn and apply the Canadian Model of Occupational Participation (CAN-MOP) and the Canadian Inter-Relational Practice Process Framework, published in Promoting Occupational Participation: Collaborative Relationship-Focused Occupational Therapy, co-authored by Egan & Restall (2022).

Risk Assessment and Rebalancing

Risk assessment and rebalancing is an important aspect of occupational therapy practice in acute care. OTs are part of a collaborative team, including the client and family, that works together to address the client's priorities and needs specific to the discharge location. Occupational therapists need to understand the basic principles of risk assessment and rebalancing and their role on the inter-professional team. This section of the guide will summarize the principles, practical considerations, and the risk rebalancing process. *See Glossary section for definitions of Risk Terminology.*

PRINCIPLES

- People need to be supported to live *with* risk rather than living *at* risk
- There is positive risk taking that supports self-efficacy
- Tolerance to risk is highly personal and reflects a client's values
- There is a need to determine whose tolerance for risk is being considered (family, client, HCP)
- Systematic approach is considered best practice
- The goal of interventions is risk rebalancing not risk elimination
- Strength based approach accesses client's strengths in risk rebalancing

PRACTICAL CONSIDERATIONS

- The clinician needs to assess their own risk tolerance and the impact on their practice. Identification of moral and ethical distress is part of the self-reflection
- Risk rebalancing is best done in collaboration with the health care team, family and client
- Consult to Ethics may be helpful when considering risk rebalancing in highly complex situations
- Consideration of decision-making capacity is considered only after least invasive interventions are considered and an alternative decision maker will benefit the client and outcome. *For more information on OT's role in this area, please refer to* Role of Occupational Therapy in the Assessment of Decision-Making Capacity Guide (albertahealthservices.ca)

RISK RE-BALANCING PROCESS – Decision Support Tool (MacLeod & Stadnyk, 2015)

*Who has the concern? (*client, family, provider)
What happens when there is a misalignment of goals?
What is the client at risk of?

- Impairments & personality, environments, perilous events, consequences
- Actual risk versus 'might be'
- Are the risk factors static or dynamic?

- Have there been previous incidences?
- Is there any patterns or trends?

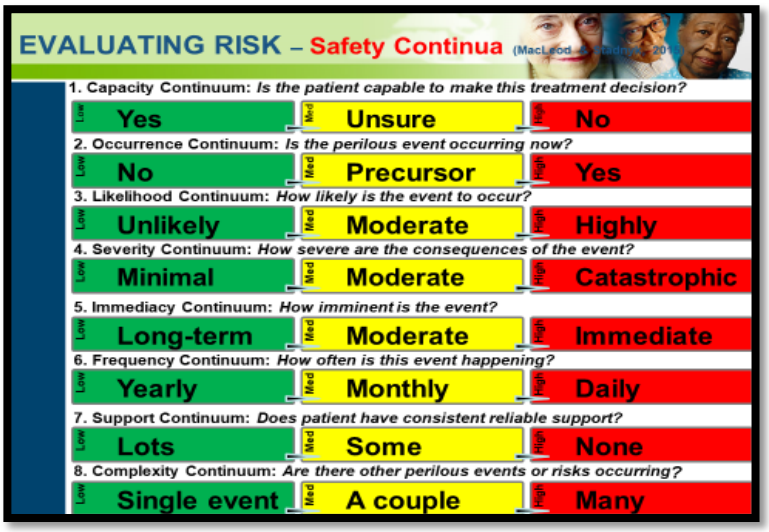
What is the risk status?

- Is the client capable to make the decision?
- Is the perilous event occurring now?
- How likely is this event or consequences to occur?
- How severe is the consequence of the event?
- How imminent is the event?
- How often is this event happening?
- Does the client have consistent, reliable support in place?
- Are there other perilous events occurring?

What can be done about it?

- Client's strengths
- Environmental adaptations and resources
- Prevention or decreased frequency of the events
- Minimizing negative consequences and augmenting positive consequences

Each of the above risk status factors can be scored on the template to the right. At a quick glance, the OT can identify the amount of risk present by the colors and identify the specific factors that need addressing (red).



From: MacLeod and Stadnyk, 2015.

Language Matters: The Impact of Occupation in Practice

Occupation language is the vehicle to support OT identity and define role clarity within the dominant medical model system. Framing daily work processes and activities which promote clinical thinking and actions through an occupation-centred lens, including the spoken and written word, embeds occupation in practice. Below are examples of questions for referral clarity, conversation starters and words to shift from medical model language to occupation language.

Describing OT role to the team

- OTs help determine how cognitive abilities are influencing a client's occupations and make suggestions on ways to address those issues
- OTs use occupations as the means and ends of therapy
- Occupations are the activities that clients need or want to do in their daily lives which they identify as meaningful
- A functional cognitive assessment looks at a client' ability to participate in everyday occupations considering not only cognitive difficulties but also *strengths, resources, routines and strategies*.
- OTs may use a cognitive screen (ACE, SLUMS, etc.) for help identify if a problem exists and then will look at how this impacts ADL/ occupations/ meaningful activities
- OTs can contribute to discussions regarding risk and risk management by articulating how cognitive abilities impact occupations
- OTs can help determine the most appropriate discharge location by considering the clients abilities and limitations

Describing OT role (to client in acute care)

- "My role is to see how you are managing your everyday occupations or activities – the things you need and want to be able to do when you leave the hospital."

Clarifying reason for referral

- "Can you help me understand what information you are looking for?"
- "What is the question you are wanting answered?"
- "What is the outcome you are hoping for?"
- "What information are you hoping can be obtained from my assessment?"
- "What are your concerns for discharging this individual home?"
- "Is the concern impacting the client's occupational activities or preventing their discharge?"

Redirecting referrals

- "The role of OT in acute care is to address occupational performance issues. Since this concern doesn't seem to be impacting the client's daily occupations (activities), it would be more appropriate to refer this to … (other HCP)." If access to other providers is a barrier, intervention would be supported in acute care
- "The concern you have brought forward does not directly impact their discharge, however, I recognize is an occupational participation concern. This concern would be best addressed by an OT in the {other setting/community} for a more comprehensive occupational assessment." If access to community OT is a barrier, intervention would be supported in acute care
- "I spoke with physiotherapy (or other HCP) who is following this client. We agree the occupational performance issues are quite straightforward and within their scope of practice so it is more efficient for them to provide this service. I've asked them to let me know if there are more complex issues that OT needs to be involved in such as functional cognitive assessment, mental health or environmental influences." Collaboration works both ways so at times OT may

be more closely involved with a client and it is more efficient for them to address activities that might fall into the scope of practice of both OT and another disciplines.

Communicating results

- "This assessment lets us know the amount and type of assistance needed to complete occupations at home."
- "I performed a Functional Cognitive Assessment as I felt it provided more valuable information than a standardized screen given the individuals culture/ education/ language background."
- "This assessment is not Pass/Fail but provides information on cognitive components such as initiation, sequencing, and safety. I then use these results as I assess the client's occupational participation to inform my recommendations specific to discharge planning."
- "The Functional Cognitive Assessment shows our client needs indirect cuing for IADLs such meal preparation. There were no safety concerns, but they have limited insight into difficulties. I recommend meals on wheels or a setting with meals provided."

Instead of saying and writing:	**Try saying and writing:**
Function	*Occupation*
Screen, informal or formal assessment	*Non-standard or standardized assessment*
Functional assessment	*Occupational assessment*
Social history	*Occupational profile or occupational history*
Smart goals	*Coast goals*
Problems identified	*Occupational performance issues*
Occupational performance	*Occupational participation*
Task analysis	*Occupational analysis*
Treatment plans	*Enablement strategies*
Therapy or treatment results	*Occupational performance outcomes*
Discharge summary	*Occupational performance summary*
Therapy Assistant (TA) delegation	*Therapy Assistant (TA) assignment*
Social justice or injustice	*Occupational justice or injustice*
Social inclusion	*Occupational inclusion*
Making assumption of client's pronoun/s	*Clarifying client's pronouns*
Safe or not safe to	*Risk mitigation/ rebalancing strategies*

Documentation Samples

Informed Consent

Consent discussed with client/alternative decision maker on this date for.... Client/ADM informed of the nature, risks, benefits, and the consequences of consenting or refusing the intervention. Client/ADM verified understanding and provided verbal consent.

Occupational Therapist - Example of Informed Consent using occupation language

Reviewed role of occupational therapist with assessing client's occupational participation and independence. Potential occupation-based and occupation-focused enablement/intervention strategies were reviewed. Risks and benefits of engaging in the occupational therapy process (and risk of declining) was outlined. Client provided verbal consent.

Therapy Assistant – Example of Informed Consent using occupation language

Reviewed role of occupational therapy assistant with engaging with client during self-care routines/practices as outlined by therapist. Discussed risks and benefits of client's participation in or not participating in their morning routines in readiness for discharge home. Client provided verbal consent.

Occupational Performance Issue (OPI) list

1. Decreased independence in occupations of dressing, hygiene and toilet and tub transfers due to poor balance, decreased UE/LE strength and impaired cognition.
2. Decreased independence in occupations of med management, meal preparation and financial management due to impaired cognition and activity tolerance.
3. Decreased occupational participation in social activities such as senior's group (exercise, socializing) at the local community center.
4. Occupational participation risk due to impaired cognition, strength, balance and activity tolerance.
5. Occupational participation risk partially mitigated by supportive family including spouse.

Occupational Participation Goals

1. Increase independence in occupations of dressing, hygiene and toilet and tub transfers by participation in TA program for morning routine 3 days per week.
2. Decrease occupational risk in med management, meal preparation and financial management by engaging family and formal supports on discharge from hospital.
3. Client will increase socialization and participation in exercises by involvement in daily therapy in the rehab department.
4. Client will be able to access community seniors group on discharge through exploration of alternative transportation means. (Family or City access)

Discharge Recommendations

1. Referral to Red Cross for raised toilet seat and bath seat to support client's occupational participation in self-care.

2. Referral to Community OT to assess for long term equipment needed to address occupational risk for transfers and occupational risk assessment of med management, meal preparation and financial management
3. Referral to community transportation services to enable client's access to occupations beyond their home environment.

Summary

Occupational therapists have a unique and valuable role in acute care in supporting successful transition from hospital and in preventing re-admission through occupation-based intervention. Specifically, this clinical guide aims to optimize OT practice and patient outcomes for the Core Clinical Activities of Activities of Daily Living and Functional Cognition. Prioritization of referrals and a standard approach to these activities supports the principle of 'right provider, right place, right time'.

Acknowledgements

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Glossary of Terms

Basic assessment: brief clinical observation and analysis of occupation (such as a self-care task) that may incorporate standardized measures such as a cognitive screening tool (i.e. SLUMS).

Comprehensive assessment: involves a more in-depth observation and analysis of occupation and may incorporate standardized measures such as performance based cognitive assessments (i.e., Kettle Test, Executive Function Performance Test).

Cognitive screening tools: brief, inexpensive tools used to identify subtle deficits in cognition or provide a global profile. They can be administered by a variety of health care providers and help answer the question, "*Is there a problem?"* Examples include the *SLUMS, RUDAS, or Trail Making Test.*

Cognitive assessment tools: in depth tools that provide more detailed information about performance-based skills or specific cognitive domains. They are administered by professionals with some expertise in cognitive assessment and help answer specific questions such as *"What kind of problem? What is the degree of the problem? What is the impact of the problem in a specific context?"*

Core Clinical Activities (CCAs): commonly delivered, evidence-informed interventions, essential to client and family centred care, and appropriate for the practice of a discipline.

Occupation-centred – holding occupation as the central focus of therapy and aligning practice with the core theoretical tenets of the profession.

Occupation-based – direct engagement in occupation as the means of evaluation and intervention.

Occupation-focused – occupation is held in proximal focus; occupations may not be the medium used in therapy; however, occupational engagement is the intended outcome of therapy.

Performance Based Assessment – Assessments presented in the form of potentially familiar ADL or IADL tasks, such that performance can be influenced by the client's use of strategies and previously acquired performance skills. In general, these assessment tasks have more than one route to satisfactory performance, have greater cognitive than physical emphasis, and require the integration of multiple sources of information and the sequencing of multiple action steps for goal completion. (AOTA, 2019).

Risk – "A time bound decision-making situation where the outcomes are uncertain and where the benefits are sought, but undesirable outcomes are possible" (Taylor, 2010)

Living at risk – "A judgment about an impairment within an environment that can cause a perilous event that has the increased potential for a negative consequence" (MacLeod & Stadnyk, 2015).

Living with risk - Broadened definition of risk and acknowledgement of the benefits of taking risks

"Focusing on optimizing client's health, leveraging their strengths, adapting the environment, minimizing or preventing perilous events, minimizing negative consequences, optimizing positive consequences and acknowledging physical and emotional consequences." (MacLeod, 2019)

Tolerable Risk- Changes in person's abilities that do not necessarily place them at an increased risk of harm (Cott & Tierney, 2013)

Intolerable Risk - Risk that is often considered to be too high – not that it may, but that it will happen with a demonstrated history (Cott & Tierney, 2013)

Risk rebalancing - When red flags are present, the health care team and family engage in a process to achieve acceptable risk by re-establishing balance (Cott & Tierney, 2013)

References

Alberta Health Services. (2017). Cognitive/Functional Assessments: The role of occupational therapy in acute care (AHS). Retrieved from: https://insite.albertahealthservices.ca/main/assets/tms/ahc/tms-ahc-role-document-ot-cognitive-assessments-in-acute-care.pdf

Alberta Health Services. (2021). Core Clinical Activities at a glance. Retrieved from: https://extranet.ahsnet.ca/teams/HPSP/AHPPE/PracticeHub/Shared%20Documents/Core_Clinical_Activities_at_a_Glance_One_Pager.pdf

Alberta Health Services. (2021). Occupational Therapy Service Standard Acute Care Adult (ADL & Functional Cognition. Retrieved from: https://insite.albertahealthservices.ca/main/assets/tms/hpsp/tms-hpsp-ss-ot-acute-care-adl-functional-cognition-priorization.pdf

AHS Planning & Performance. (2020). AHS Report on Performance Q3 2019-20 - Unplanned Medical Readmission. https://www.albertahealthservices.ca/assets/about/publications/ahs-pub-pr-2019-20-q3-objective-05.pdf

American Occupational Therapy Association. (2019). Cognition, cognitive rehabilitation, and occupational performance. *American Journal of Occupational Therapy.* 73(Supplement_2):7312410010p1-7312410010p26. DOI: 10.5014/ajot.2019.73S201

American Occupational Therapy Association. (2018 June 04). 'Ten things patients and providers should question." https://www.choosingwisely.org/societies/american-occupational-therapy-association-inc/

Barco, P.P., Gillen, G., & Wolf, T.J. (2020). Intervention selection: Learning and concepts of transfer. In Wolf, T.J., Edwards, D.F. & Giles, G.M. (Eds) *Functional cognition and occupational therapy: A practical approach to treating individuals with cognitive loss.* (pp. 179-188).

Boone, A. E., Henderson, W. L., & Dunn, W. (2022). The Issue Is—Screening tools: They're so quick! What's the issue? *American Journal of Occupational Therapy,* 76, 7602347010. https://doi.org/10.5014/ajot.2022.049331

Cott, C.A. & Tierney, M.C. (2013). Acceptable and unacceptable risk: balancing everyday risk by family members of older cognitively impaired adults who live alone. *Health, Risk & Society, 15* (5): 402-415.

Di Tommaso, A., Isbel, S., Scarvell, J., & Wicks. (2016). Occupational therapists' perceptions of occupation in practice: an exploratory study. *Australian Occupational Therapy Journal*. 63, 206 – 213.

Dodson, J.A., Hajduk, A.M., Murphy, T.E., Geda, M., Krumholz., H.M., Tsang, S., Nanna, M.G., Tinetti, M.E., Goldstein, D., Forman, D.E., Alexander, K.P., Gill, T.M. & Chaudhry, S.I. (2019). Thirty-day readmission risk model for older adults hospitalized with acute myocardial infarction: The SILVER-AMI Study. *Circulation: Cardiovascular Quality and Outcomes.* 2019, 12:e005320.

Egan, M. & Restall, G. (2022*). Promoting occupational participation: Collaborative relationship-focused occupational therapy.* CAOT Publishing ACE.

Fisher, A. (2013). Occupation-centred, occupation-based, occupation-focused: Same, same or different? *Scandinavian Journal of Occupational Therapy*, 20:3, 162 – 173.

Ford, E., Di Tommaso, A., Gustafsson, L., & Molineux, M. (2021). Describing the occupational nature of practice: A scoping review. *Scandinavian Journal of Occupational Therapy,* doi.org/10.1080/11038128.2021.1968949.

Gateley, C.A. & Borcherding, S. (2012) Documentation manual for occupational therapy: Writing SOAP notes, 3rd ed. Thorofare, NJ: SLACK Incorporated.

Giles, G. M., Edwards, D. F., Baum, C., Furniss, J., Skidmore, E., Wolf, T., & Leland, N. E. (2020). Making functional cognition a professional priority. *American Journal of Occupational Therapy, 74(*1), 7401090010p1-7401090010p6.

Greysen, S. R., Cenzer, I. S., Auerbach, A. D., & Covinsky, K. E. (2015). Functional impairment and hospital readmission in Medicare seniors. *JAMA Internal Medicine, 175*(4), 559-565.

Hocking, C. (2001). Implementing occupation-based assessment. The American Journal of Occupational Therapy, 55 (4), 463–469. https://doi.org/10.5014/ajot.55.4.463

Jonsson, M., Appelros, P., & Fredriksson, C. (2017). Older people readmitted to hospital for acute medical care: Implications for occupational therapy. *Scandinavian Journal of Occupational Therapy*, 24 (2): 143-150. doi: 10.1080/11038128.2016.1227367.

Lockwood, K.J. & Porter, J. (2022). Effectiveness of hospital-based interventions by occupational therapy practitioners on reducing readmissions: A systematic review with meta-analyses. *The American Journal of Occupational Therapy*, 2022, Vol. 76(1), 7601180050.

MacLeod, H. and Stadnyk, R.L. (2015). Risk: 'I know it when I see it': How health and social practitioners defined and evaluated living at risk among community-dwelling older adults. *Health, Risk & Society*, *17(*1): 46-63.

Murray, A., Di Tommaso, A., Molineux, M., Young, A., & Power, P. (2021). Contemporary occupational therapy philosophy and practice in hospital settings. *Scandinavian Journal of Occupational Therapy,* 28 (3); 213-224.

Roberts, P., Robinson, M., Furniss, J., & Metzler, C. (2020). Health Policy Perspectives—Occupational therapy's value in provision of quality care to prevent readmissions. *American Journal of Occupational Therapy*, 74, 7403090010. https://doi.org/10.5014/ajot.2020.743002

Rogers, A.T., Bai, G., Lavin, R.A., & Anderson, G.F. (2016). Higher hospital spending on occupational therapy is associated with lower readmission rates. *Medical Care Research and Review*. 74(6) 668 –686.

Smith-Gabai, H., & Holm, S. (2017). *Occupational therapy in acute care* (2 ed.) AOTA Press.

Townsend, E. A., & Polatajko, H. J. (2013). *Enabling occupation II: Advancing an occupational therapy vision for health, well-being, & justice through occupation* (2nd ed.). CAOT Publishing ACE.

Uruma, M., Momosaki, R., Chono, M., Watanabe, T., Nakamura, M., & Abo, M. (2019). Effectiveness of acute in-hospital occupational therapy for older adults with hip fractures. *Geriatrics & Gerontology International,* 19(7), 611 – 615.

Wesson, J., & Giles, G.M. (2019). Understanding functional cognition. In Wolf, T.J., Edwards, D. F., & Giles, G.M. (Eds) *Functional Cognition and Occupational Therapy: A practical approach to treating individuals with cognitive loss*. (pp. 7-21). AOTA Press.

Wilding, C., & Whiteford, G. (2007). Occupation and occupational therapy: Knowledge paradigms and everyday practice. *Australian Occupational Therapy Journal, 54*(3), 185-193.

Appendix A: Resources and Recommended Readings

TEXTBOOKS

Wolf, T.J., Edwards, D.F., and Giles, G.M. (2019). *Functional cognition and occupational therapy: A practical approach to treating individuals with cognitive loss.* AOTA Press.

* eBook available from AHS Knowledge Resource Service.

Gillen, G. (2009) Cognitive *and perceptual rehabilitation: Optimizing function*. Mosby Elsevier.

ARTICLES

Cognitive Screening

Boone, A. E., Henderson, W. L., & Dunn, W. (2022). Screening tools: They're so quick! What's the issue? *American Journal of Occupational Therapy*, 76, 7602347010. https://doi.org/10.5014/ajot.2022.049331

Functional Cognition

Roberts, P., Robinson, M., Furniss, J., & Metzler, C. (2020). Occupational therapy's value in provision of quality care to prevent readmissions. *American Journal of Occupational Therapy, 74*(3), 7403090010p1-7403090010p9. https://doi.org/10.5014/ajot.2020.743002

Hull, K. (2021). A Transition to Occupation-Based Care: Implementing AOTAs Choosing Wisely recommendations in a medical model rehabilitation setting. *OT PRACTICE*, p. 21-24.

Giles, G. M., Edwards, D. F., Baum, C., Furniss, J., Skidmore, E., Wolf, T., & Leland, N. E. (2020). Making functional cognition a professional priority. *American Journal of Occupational Therapy, 74(*1), 7401090010p1-7401090010p6. DOI: 10.5014/ajot.2020.741002

AOTA (2019). Cognition, cognitive rehabilitation, and occupational performance. *American Journal of Occupational Therapy.* 73; (Supplement_2):7312410010p1-7312410010p26. DOI: 10.5014/ajot.2019.73S201***Includes six case examples of different populations and cognitive rehab approaches.*

Occupation-Centred Practice

Britton, L., Rosenwax, L., & McNamara, B. (2015). Occupational therapy practice in acute physical hospital settings: Evidence from a scoping review. *Australian Occupational Therapy Journal*, 62, 370 – 377.

Di Tommaso, A. & Wilding, C. (2014). Exploring ways to improve descriptions in occupational therapy. *New Zealand Journal of Occupational Therapy,* 61(1), 25 – 31.

Fisher, A. (2013). Occupation-centred, occupation-based, occupation-focused: Same, same or different? *Scandinavian Journal of Occupational Therapy*, 20:3, 162 – 173.

Ford, E., Di Tommaso, A., Gustafsson, L., & Molineux, M. (2021). Describing the occupational nature of practice: A scoping review. *Scandinavian Journal of Occupational Therapy,* doi.org/10.1080/11038128.2021.1968949.

Gillen, A. & Greber, C. (2014). Occupational-focused practice: challenges and choices. *British Journal of Occupational Therapy*, 77(1), 39 – 41.

Fortune, T. (2000). Occupational therapists: is our therapy truly occupational or are we merely filling gaps? *British Journal of Occupational Therapy*, May 63(5), 225 – 230.

Hocking, C. (2001). Implementing occupation-based assessment. *The American Journal of Occupational Therapy*, 55 (4), 463–469. https://doi.org/10.5014/ajot.55.4.463

Psillas, S. & Stav W. (2021). Development of the dynamic model of occupation-based practice. *The Open Journal of Occupational Therapy*, 9(4), 1 – 14.

Whiteford, G., Jones, K., Weekes, G., Ndlovu, N. & Long, C. (2021). Doing and being occupation centred in challenging settings: reflections on implementation strategies and professional rewards. *Cadernos Brasileiros de Terapia Ocupacional*, 29, e3011.

Wilding, C. & Whiteford, G. (2008). Language, identity and representation: Occupation and occupational therapy in acute settings. *Australian Journal of Occupational Therapy*, 55, 180 – 197.

Wilding, C. & Whiteford, G. (2009). From practice to praxis: reconnection moral vision with philosophical underpinnings. *British Journal of Occupational Therapy*, 72(10), 434 – 441.

WEBSITES/ON-LINE RESOURCES

AOTA Choosing Wisely https://www.choosingwisely.org/societies/american-occupational-therapy-association-inc/

AHS Cognitive/Functional Assessments: OTs role in acute care. Role Document - OT Cognitive Assessments In Acute Care - Jan. 2017 (albertahealthservices.ca)

AHS Guide to Cognitive Screening: Cognitive Screening | Insite (albertahealthservices.ca)

VCH OT Approach to Cognition/Perception (2013) http://www.vch.ca/Documents/Occupational-therapy-approach-to-evaluation-of-cognition-perception.pdf

VCH OT Approach to Cognitive Interventions (2018) http://www.vch.ca/Documents/Occupational-therapy-cognitive-rehabiliation-intervention.pdf

COAST format for goal writing (https://www.youtube.com/watch?v=1uepV5iXmg4)

ACRM Cognitive Rehabilitation Manual
https://acrm.org/wp-content/uploads/pdf/COG_Manual_020413_frontSection.pdf

Multicontext approach to Cognition https://multicontext.net/