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Home Safety and Caregiver Support to a Community Organization:

**Description**
In this project, occupational therapy students worked with Washington County Aging, Disability and Veterans Services to determine the needs of agency intake staff who evaluate elders and caregivers who wish to remain in their own homes. An easily completed home assessment form was created to help target needs for additional services. Students also recommended the use of a quality of life assessment to determine the needs for respite care as a means to identify successful outcomes of agency services. Focus groups determined the effectiveness of and satisfaction with the model by intake staff.

**Disciplines**
Occupational Therapy | Rehabilitation and Therapy

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Home Safety and Caregiver Support to a Community Organization: An Innovative Practice Project

Ashley Becker & Melanie Hall

Pacific University
The aging population in the nation is rising exponentially. According to the United States Census Bureau, currently citizens aged 65 or older constitute 12% of the total United States population. This number is projected to rise significantly in the next 25 years. The projection is largely based on the Baby Boomer population. Baby Boomers will first turn 65 in 2011, increasing this age group to 35 million residents. In 2030, it is anticipated that the population will reach 72 million, representing virtually 20% of the entire United States population (He, Sengupta, Velkoff, & Debarros, 2005).

With the influx of older adults, so will the caregiver population increase. It is estimated that between 22 million and 33.9 million adults provide unpaid care to Americans aged 50 or older, and that this number is expected to nearly double by the year 2050 (Department of Health and Human Service [HHS] & Department of Labor [DOL], 2003; National Alliance for Caregiving [NAC] & AARP, 2004). Locally, this is also true. The number of caregivers in Oregon in 2008 was estimated to be 410,000 at any given time (Houser & Gibson, 2008). According to the US Census Bureau (2010), Washington County's population in 2008 was 528,216, which constitutes about 10.8 percent of the total population of Oregon. This number indicates that there are approximately 57,000 caregivers in Washington County.

The Need for Occupational Therapy in Community Organizations

Where is the best environment for occupational therapists to work with the older adult and caregiver population to best support their well-being? There are numerous constraints to effective client-centered practice in hospitals, skilled nursing facilities, or other institutions due to productivity demands and economics. Institutions incur high costs for inpatient care and additionally, there is limited contact time to acknowledge client goals and to allow them to make
informed decisions (Meyers, 2010). Occupational Therapy in community practice aims to work with clients within their naturally occurring environments. When we shift occupational therapy services from the hospital to the community, client-centered care becomes a natural basis on which to build treatment. When treatment shifts to community environments such as the home, usually there is more time to develop an understanding of the client's or caregiver's performance needs and constraints. By visiting the client's homes, the OT can accurately assess the structural layout and note architectural barriers, along with the psychological supports and barriers within that environment. Spending time in the home environment, client's can perform activities of daily living (ADL) and the OT can consider intervention options from within an economical and cultural understanding of the client. The occupational therapist does not need to visualize or wonder whether interventions provided will readily transfer to the client home environment; interventions occur in the home. This way, the OT, the caregiver, and the recipient of care can problem solve together about how to make their home safer and more accessible. Therapy becomes a daily part of life as the clients' are able to manage and become more independent, safe, and capable of performing personally meaningful activities.

**Benefits of supporting caregivers**

Occupational therapy can improve the daily performance, communication, sense of competence and quality of life of the caregiver and the elderly recipient of care. The National Family Caregivers Association (2001) found that over 90% of family caregivers become more proactive about seeking resources and skills they need to assist their care recipient after they have self-identified. Identifying the need for caregiver services can be based upon quality of life assessments administered either from The Caregivers' Wellness Center or from other Washington County aging and disability services. Measures of quality of life include constructs
such as physical, emotional, and cognitive functioning, self-rated health, self-efficacy, spirituality, financial status, social support, and satisfaction with life (Vellone, Talucci, & Cohen, 2008).

There is plentiful evidence that interventions supporting caregivers lead to greater caregiver health and well being. Chappell & Reid (2002) found that caregiver perception of increased social support is positively correlated with caregiver wellbeing. A formalized social group for caregivers could serve to increase their perceived social support and decrease social isolation, thereby leading to greater well-being (Brodaty & Hadzi-Pavlovic, 1990). Working with the caregiver to identify personal values that are being satisfied by the caregiving experience and find ways to optimize those is also beneficial. A study of Alzheimer disease caregivers found that only 15% reported provisional meaning in their caregiving, and having sense of meaning in caregiving is known to reduce depressive symptoms (Farran, Kean-Hagerty, Salloway, Kupferer & Wilken, 1991; Noonan & Tennstedt, 1997). For example, spirituality and faith were domains uniquely identified by caregivers from minority groups. Given the diverse ethnic population of Washington County, it’s paramount to address these aspects to benefit caregivers quality of life. Caregiver education programs can serve to assist caregivers in developing optimal management and coping strategies, which have been correlated with higher caregiver well-being (Hinrichsen & Niederehe, 1994; Li, Seltzer & Greeberg, 1999). In addition, it has been recommended that physical health promotion, such as opportunities for exercise and nutrition, be included in caregiver interventions (Pinquart and Sorenson, 2007).

The National Institute on Aging and the National Institute for Nursing Research have conducted an extensive research effort, the Resources for Enhancing Alzheimer's Caregiver Health (REACH) study, on effective methods for assisting caregivers in managing the demands
of caregiving. Researchers found that programs involving a wide range of intervention strategies were more effective than single, targeted interventions. Specific areas of intervention in their study included depression, burden, self-care and healthy behaviors, social support, and problem behaviors (Gitlin et. al., 2003). These areas are commonly addressed by occupational therapists, and a community-based center would be an ideal setting to employ this multi-faceted approach.

**Issues Facing Caregivers**

There are substantial studies and decades of research to confirm that being a family caregiver is a stressful role. The chronic stress associated with caregiving for a disabled elder has been found to affect several dimensions of caregiver health, including social and emotional health. High caregiver burden scores on quality of life assessments are indicative of decreased mental and physical health, as well as compromised vitality and social functioning. There is very little personal time left for the caregiver to take care of their own needs. Nearly one in five provide more than 40 hours of care per week and one-third (28%) of caregivers who provide more than 40 hours of care per week are 65+ years. According to Son et. al., (2010) providing care to a family member with dementia can be a 24-hour responsibility that requires hands-on assistance and supervision. The amount of time spent caring increases substantially as cognitive impairments worsens.

Numerous studies have looked at the effects of caregiving on psychological and physical health. Caregiving for an elderly individual with a disability has been directly correlated with increased rates of depression and anxiety (Schultz & Martire, 2004). The impact on a caregiver’s physical health has been evidenced by decreased immune response, increased stress hormones, increased risk for coronary heart disease, and increased mortality (Lee, Colditz, Berkman, & Kawachi, 2003; Schultz & Beach, 1999; Vitaliano, Zhang and Scanlan, 2003).
Furthermore, the demands on caregivers' time and energy puts them at a high risk for neglecting their own self-care: not exercising, eating, resting, acquiring medical attention or socializing in an optimal way. (Beach, Schultz, Yee & Jackson, 2000; Schultz et al., 1997).

**Issues Affecting Older Adults**

Every year, a minimum of one third of adults 65 and older fall in the United States. These incidents are the leading cause of injury deaths and account for the most common cause of nonfatal injuries and hospital admissions for trauma. About a quarter of individuals sustain moderate to severe injuries such as bruises, fractures and head injuries. In fact, falls are the most common cause of traumatic brain injury for this population and accounted for 46% of fatalities from falls in 2000. Those who survive falls make mobility more difficult and can be a barrier to independent living. With lower endurance from not getting enough activity due to increased fear of falling, the individual is at a higher risk of falling again (Centers for Disease Control [CDC], 2003). Not only is this problematic for this population, it is expensive. Medical costs totaled $0.2 billion for fatal falls and $19 billion for nonfatal fall injuries in 2000 (Stevens et al. 2006). With proper education along with environmental modifications, most falls can be prevented allowing older adults to live independently in their homes.

Factors that contribute to falls include current or recent illness, the individual's physical capabilities such as strength and endurance, medication and fear of falling. Those especially at risk are older adults with low vision, perceptual disorders and weakness. Factors outside the individual can put them at risk as well, such as hazards in the home, the type of shoes the individual wears and the absence of mobility devices. Many hazards in the home have easy fixes. Inadequate lighting and floor rugs without skid backing can increase an older adult's risk for falling, but are some of the more inexpensive ways to make the individual safer. More costly
adaptations can be used to repair dangerous areas of the home such as placing railings in stairways and grab bars in bathtubs (AOTA, 2009).

Many programs and trails have been implemented to address this epidemic. A recent study by Frick, Kung, Parrish and Narrett (2010) investigated many studies for prevention. They found that home safety assessments are among the most cost effective method of fall prevention and most beneficial for clients with low vision or who are at an already increased fall risk due to health problems and weakness. The most effective intervention for falls for all groups is exercise, including Tai Chi.

Due to the information and research provided above, the students of this Innovative Practice Project concluded that providing a caregiver quality of life survey and a home safety assessment could provide the most assistance for case managers working with the older adult and caregiver population in Washington county. In this initial stage of partnership between Pacific University and Washington County Aging, Disability and Veterans Services (WCDAVS), the assessments have been provided in hopes of eventual occupational therapy services being offered through the county organization.

The Caregiver Strain Index is a brief 13 item questionnaire that measures caregiver strain, which the assessment defines as a combination of stress and burden that has consequences on caregivers' overall health (Robinson, 1983, Van Exel et al, 2004). This assessment has been compared with other caregiver quality of life questionnaires and although it is brief, it has proven just as valid and yields important information as longer assessments. In the few items, it identifies strain regarding physical health, family finances, social interactions, time demands and employment. This allows the interviewer insight in where assistance could be provided to the caregiver to alleviate strain. Through addressing these areas, the outcome of using this
assessments are increased self-sufficiency, self-efficacy, healthy roles, habits and routines, sense of control and quality of life (Van Exel et al., 2004).

This assessment has been used to measure success of health care based programs for caregivers as a pre and post measure to determine program efficacy (Wolff, Rand-Giovannetti, Palmer, Wegener et al., 2009). Due to the ability for the assessment to be used as not only a tool that can pinpoint areas of caregiver strain to be addressed, DAVS could also use the assessment as an outcome measure to support the effectiveness of the services offered to caregivers. The Caregiver Strain has been used cross-culturally and with caregivers of children of disabilities (Tsai & Wang, 2009).

Research has shown that Safety-proofing the living environment through home modification has been decreases the risk of falls for older adults. Home visits by skilled practitioners, such as social workers and occupational therapists can prevent falls for people who are at risk for falling. Furthermore, visits by practitioners may also lead to changes in behavior that enable older people to live more independently in their home environment. Many assessments supporting development and dissemination of home modification solutions have been published. Assessing and improving home safety and modifications not only keeps people safe in their homes but also improves caregiver satisfaction and client independence.

A review of existing literature on the importance for home safety assessments yielded relevant results. Literature exists on the need of home modifications and on the development of client and interprofessional collaboration to ameliorate risks and set forth prevention strategies. Facilitating ‘Aging-in-Place’ refers to programs that support and enable aging adults to avoid the need to relocate and make drastic impacting changes to one’s lifestyle. The importance of personal places imbued with memories and meanings is what makes us. Home health specialists
can use their expertise in activity, performance, and environmental analysis can help people
remain independent in their own home and communities as long as possible.

The role of caregiving is a dynamic and changeable process. Follow-up with clients is
crucial when thinking about how they use the skills we teach them within their daily lives.
Developing an understanding of the complexity of caregiving is necessary so that occupational
therapists can recognize clients' ideas, beliefs, and practices surrounding the activity of
caregiving. A holistic approach of framing the occupational therapy process and developing a
client-centered approach to treatment is to address the health problems, the relationships, and the
environment that they interact in. Our role as occupational therapists is to provide education and
practice for caregivers so that they can esteem safety and self-care. Awareness of the everyday
routines of the client's life such as housing conditions, work, family, neighborhood relationships
are an integral part in the role of developing occupationally relevant treatment plans. These
processes are dynamic interactions and interwoven, thus, follow-up is imperative in order to stay
abreast on the client's current conditions so that we may provide client-centered therapy
plans.

Due to the nature of our project, WCDAVS is the client in this case. The assessments
were provided to them, as well as a presentation to staff about the importance of home safety in
fall prevention as well as importance of supporting caregiver quality of life. It was an important
step in this process to ensure the assessments were usable and helpful for the case managers and
to assess the need for a quality of life measure for caregivers. In our literature search, many
assessments place much emphasis on the person and his/her occupational performance, however,
they do not look in a very detailed way at the specific environmental safety hazards. Not many
assessments address home safety features of the home from the standpoint of environmental
safety in an in-depth way. The intent of our focus group was to gather participant feedback so as to improve our home safety assessment and streamline its usage. The focus group participants provided us with education, advice, modification, and confirmation regarding the home safety assessment's utility and usefulness. Further, the focus group allowed for an in-depth evaluation on the Caregiver Strain Index and its usefulness for the case managers' intake sessions. In the future, Pacific University School of Occupational therapy hopes to expand this relationship with WCDAVS. We hope to serve as the liaison connecting case managers and clients to the occupational therapy resources they need in order to create a safe and supportive home environment for the caregivers and the recipients of care.
References


Hi Melanie and Ashley,
Your presenter application for the WOTA conference has been received and forwarded on to the conference committee for review. You should hear from them by mid-April. Don't hesitate to contact us if you have any questions.
Thank you for your submission.
Nancy

WOTA Annual Conference October 8 & 9th 2010
“Call For Presentations”
Hotel Murano Tacoma, WA
Complete all sections. All categories and items must be complete to be considered for acceptance. (If you are not able to submit electronically, print the form, complete and FAX to 253-826-0140)

1. TITLE OF PRESENTATION: Helping Occupational Therapists connect with Community Organizations

2. PRIMARY PRESENTER:

NAME: Ashley Becker and Melanie Hall
TITLE: Occupational therapy students, anticipated graduation May 2010
ADDRESS: 1736 SW Marlow Ave. Portland, OR 97225
EMPLOYER: School – Pacific University, Occupational Therapy Master’s Program
HOME PHONE:
CELL PHONE: (503)347-6557
WORK:
FAX:
EMAIL ADDRESS: pumot3@gmail.com
*Please note, only the primary presenter will receive notification of acceptance or denial, and all future conference related material.

ADDITIONAL PRESENTERS:
Name:
Address:
Name:
Address:

3. PREREQUISITE EXPERIENCE WITH SUBJECT: (Check applicable audience)
   _ Students
   _ Beginner level (<4 years)
   _ Intermediate (5-9 years)
   _ Advanced (>10 years)
   _ Re-entry level (out of practice several years)
   X MIXED

4. CONTENT AREA: (Indicate primary area)
   _ Productive Aging/Aging in Place _ Mental Health _ Physical Disabilities
   _ Children & Youth _ Academics/Fieldwork/Research _ Health & Wellness _ Professional Issues
   _ Work & Industry
5. SESSION TYPE: (Choose one)
   __X__ Workshop. A workshop provides 90 minutes of in-depth instruction. Presenters are encouraged to use a variety of instructional methods and media. Presenters should allow sufficient time for participant questions and discussion and completion of the post-test with review toward the end of the session (5-15 minutes).
Intensive Session. Sessions of this type will be two and a half hours in length and contain detailed material. These sessions will be “intense” in terms of the quantity of material, the level of prerequisite skill necessary on the part of attendees, and/or the learning format. Intensive sessions will require one scheduled 15 min break for the attendees and should allow for participant questions and discussion and completion of the post-test with review.

Poster. Posters are visual displays of occupational therapy topics such as innovative treatment approaches, specialized programs, and research endeavors. Poster presenters are required to submit an abstract of their proposal, specific learning objectives, the importance of the topic proposed and the relation to occupational therapy practice, and background information with current references to support the topic. Posters must be no larger than 4 x 8 feet; no audiovisual or other equipment will be provided. Poster presenters must be present during the formal poster session to discuss his/her work with conference attendees. Poster presenters are required to obtain signatures of participants for an attendance record and provide a post-test to the attendees of the poster presentation in order for participants to receive continuing education credit.

6. PROGRAM ABSTRACT: (Description of presentation for conference program)
Please limit length to seventy-five words for an Intensive, fifty words for a Workshop session, and thirty for a Poster session. Abstracts greater than these limits will be edited at the discretion of the conference committee.

Occupational therapy students will present the process of their Innovative Practice Project, in which they worked with eldercare agencies to determine needs of intake staff and created a home assessment that helps target need for additional services. A caregiver quality of life questionnaire was also provided to measure agency outcomes.

7. PROGRAM DESCRIPTION:
Please provide a more detailed description (up to 350 words) that includes content, learning objectives*, and post test* (to meet licensure continuing education requirements), teaching methods and content level (entry, intermediate, advanced, etc.)
Post-tests for sessions are required for participants meeting the session objectives and meeting AOTA requirements for Continuing Education (CE) credits. Post-tests should have the title of the session on top, a line for each participant to print their name, and five to ten multiple choice or T/F questions. The presenter is responsible for supplying handouts and printed post-tests for their session, scoring the post-tests and turning them in to WOTA at conference. All post-test questions must relate to content taught during your session and it is advised that you go over the test at the end of your session.

I have read and understand the requirements (please initial) ______________

In this innovative practice model, occupational therapy students worked with eldercare agencies to determine needs of agency intake staff who evaluate elders and caregivers who wish to remain in their own homes. Students created an easily completed home assessment form which helps target needs for additional services. Students also recommended the use of a quality of life assessment to determine the needs for respite care as a means to identify successful outcomes of agency services. Focus groups determined the effectiveness of and satisfaction with the model by intake staff.
Learning Objectives:
1) Develop mutual goals to establish partnerships between health/human service agencies and health sciences students as part of community service learning/clinical education.
2) Identify content for home assessment relevant to the local community.
3) Establish agency staff educational objectives and content.
4) Understand use of home or caregiver assessments to support outcomes of the agency.
5) Make use of available resources.

*POST TEST - I am sending an electronic copy of my Post-test and answer key with the above requirements along with this application. (Must be included to be considered for acceptance)

(Initial) ______________

8. EQUIPMENT: WOTA is able to provide a LCD and projection screen. Please place an “X” in the box only if you will require one. The speaker/presenter is responsible for any additional audio-visual equipment/supplies such as laser pointers, white boards, markers, etc. (Note: WOTA is not able to provide computers, TVs, DVD or VCR players)
Yes, I will need a Projection screen/LCD __ X ____

Special Requests for consideration:
9. Number of participants I would like my session limited to: (if any) __ open____
Class room sizes can seat up to 50 participants
Please set my room up with _______ tables and chairs (holds 30 participants), OR ___X____ chairs
Only (holds 50 participants)
10. AVAILABILITY: Please indicate your tentative preference for your presentation. Please note that once the program schedule is complete, no changes can be made. Please be cautious when identifying your availability. We will do everything to attempt to give you your specified date, however please note that you may have to accept an alternative to accommodate the conference schedule.
Friday OR Saturday _____
Friday Only ___ PM _____
Saturday Only ____ Anytime __
AM _____ PM _____ Anytime _____
I require special accommodations: (Please list)

Recognition for Presenters:
Workshop and Intensive Sessions:
Up to two presenters per session will receive Lunch and Continuing Education credit for the lunch presentation on the day of their presentation (presenters must attend and sign in for the lunch session in order to obtain the CE). If you have more than two presenters for your session, additional lunch tickets may be purchased for $20.00 at the registration desk. Each session will receive ONE free WOTA membership. This membership is non-transferable and cannot be split between presenters. In the event that you present in more than one session, there is a maximum of one free WOTA membership, per conference year. (Recognition is valued at up to $225.00 per session)

*I would like receive my FREE membership (applied after conference): ____X____ Yes ____ No
If more than one presenter, please apply FREE membership to:
Ashley Becker
*I am NOT registering for conference this year and I would like to have lunch on the day of my presentation
____X____ YES, ___2___ Number of presenters (up to 2) _____ Regular lunch _____ Vegetarian lunch
_____ NO lunch(s)
*Yes, I would like to order and pay for additional lunches at $20.00 per lunch. (Please pay for your lunch ticket on the day of your presentation at the registration desk)
Number of additional lunches ___________
*Each Poster Presenter will go into a drawing for one free WOTA membership.
_____ Yes, I would like lunch on the day of my poster presentation and I AM NOT registering for conference. _____ Regular Lunch _____ Vegetarian Lunch
*All presenters are required to register and pay for conference to reserve space in any additional conference sessions they are not presenting in. Please see the conference brochure online for deadlines for early bird, regular or late conference registration. These deadlines apply to presenters as well as attendees. Initial ______
Primary Presenter: Date:
Please submit an electronic signature by typing your name and date in the spaces above.
BE SURE TO PRINT A COPY OF YOUR COMPLETED APPLICATION and FAX to 253-826-0140
Washington Occupational Therapy Association

Conflict of Interest Disclosure
As a provider of Continuing Education under the auspices of the American Occupational Therapy Association (AOTA) Approved Provider Program (APP), the Washington Occupational Therapy Association (WOTA) must assure balance, independence, objectivity and scientific rigor in all its sponsored educational activities. All individuals who participate in sponsored activities are expected to disclose any significant relationships that may pose a conflict with the principles of balance and independence. The following questionnaire will help to evaluate potential conflicts of interest among speakers of the following CE activity: Washington State Occupational Therapy Association 2010 Annual Conference, October 8 & 9
Presentation Title:
Presenter Name:
Check any commercial, financial, or research relationships or interests within the past 12 months that you, your spouse, or an immediate member of your family, have that might affect your ability to provide a fair and balanced presentation for the proposed CE activity. Consider also, and check, if an organization that you have an affiliation with might benefit from the subject of the proposed CE activity.
Grants / Research Support Yes _X_ No ___
Consultant / Speaker Bureau Yes___ No _X_
Advisory Board Membership Yes ___ No _X_
Stockholder Yes ___ No _X_
Honorarium Recipient Yes ___ No _X_
Editorial Board Involvement Yes ___ No _X_
Other Material Financial Support Yes ____ No _X_
Name of commercial organization/s providing above support: 5
Having an interest or affiliation with a corporate organization does not necessarily prevent you from participating in the proposed CE activity. However, AOTA APP CE policies describe procedures for resolving conflicts of interest that may require limiting the role and input of any person judged to have a conflict. **By signing “I accept” to the above information you are attesting it to be true to the best of your information and belief. This statement will be maintained in the WOTA office as a record of your compliance with the requirements of WOTA and the AOTA APP.**

**Primary Presenter: Ashley Becker, OTS and Melanie Hall, OTS**  
**Date: March 29, 2010**

*Please submit an electronic signature by typing your name and date in the spaces above.
Send this form electronically to WOTA at intouch@wota.org or FAX 253-862-0140
(Initial__________) I am sending my post test and post test key and any supplemental sheet, electronically with this application, to the Conference Committee by March 30, 2010. If you are unable to complete this document electronically, please contact WOTA.

**Emails of acceptance or regret will be sent out on April 1, 2010**

**Helping Occupational Therapists Connect with Community Organizations**

**Post-Test**

1. Which of the following are major concerns in preventing falls?
   a) Decreased lighting
   b) Appearing unsteady when transitioning from sit to stand or while standing and walking
   c) Only B
   d) Both A and B

2. Caregiver strain as defined by the Caregiver Strain Index (Van Exel et al, 2004) is a combination of stress and burden that has consequences on caregivers’ overall health. True or False (circle one)

3. Which areas of concern are not identified through use of the Caregiver Strain Index?
   a) Caregiver’s quality of life
   b) Care receiver’s quality of life
   c) Caregiver’s sense of control
   d) Caregiver’s healthy roles, habits and routines

4. When establishing contact with a community organization to promote occupational therapy services, what is the first step of the process?
   a) Create an intervention based from an occupational therapy perspective
b) Present an idea

c) Establish organizational needs assessment through interview with staff workers or those directly receiving services
d) Evaluate what the organization currently practices

5. Which one of the following is not a detriment directly related to Caregiver burden?

a) Depression

b) Heart Disease

c) Less engagement to promote own health

d) Anxiety

Helping Occupational Therapists Connect with Community Organizations

Post-Test

Answer Key

1. D
2. T
3. B
4. C
5. B
PACIFIC UNIVERSITY
SCHOOL OF OCCUPATIONAL THERAPY

Innovative Practice Project
Ashley Becker, OTS & Melanie Hall, OTS

Informed Consent for Participation in Focus Group

Home Safety Assessment and Caregiver Strain Index Focus Group
Date: April 19, 2010

I. Purpose of Focus Group
You are invited to participate in a focus group to offer feedback regarding the Home Safety Assessment and Caregiver Strain Index that were provided to staff and volunteers of Washington County Disability, Aging and Veterans Services. The purpose of the focus group is to determine usability and appropriateness of the tools. The students at Pacific University wish to further our partnership with DAVS and benefit the caregiver population.

The information received will be used to make any necessary changes to the Home Safety Assessment and determine whether the Caregiver Strain Index is useful. Students will use focus group information during a presentation to the community as part of the IPP assignment.

II. Procedure
The Pacific University students will facilitate a discussion through asking several predetermined questions and receive any input provided from staff and volunteers who have used or looked at the assessments. The discussion has been allotted approximately 45 minutes to complete. Your participation in this focus group is entirely voluntary and you are free to leave at any time. A transcriber will take notes to gather information stated during the focus group in order to accurately represent the discussion. There are no right or wrong answers to the questions raised to the group. Any information provided regarding your opinion and/or experience is valuable. The input received will remain confidential. Statements will be recorded anonymously.

III. Risks
There is a slight risk that the discussion may cause emotional distress, however, we do not anticipate this occurring.

IV. Benefits
Information yielded from focus group participants will make it possible for staff and volunteers of DAVS to enhance quality of services to intended populations.

V. Compensation
Lunch will be provided.

VI. Participant’s Permission
I have read the Consent Form and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent:
Should I have any pertinent questions about this focus group or its conduct, and focus group participants’ rights, I may contact:
Ashley Becker, OTS and Melanie Hall, OTS
Pumot3@gmail.com
Focus Group Questions

April 19th, 2010

Home Assessment

Facilitators: Ashley Becker & Melanie Hall
Assistant Moderator/Transcriber: Nancy Krusen

1) Opening (2 min):
   • Welcome, make introductions and thank participants.
   • Review the purpose of the focus group interview.
   • Review the ground rules: “everyone’s ideas are important and everyone has an opportunity to speak. There are no right or wrong answers; even negative comments are useful in gaining insight about the topic under discussion.
     All comments are confidential and only summarized information will be communicated.”
   • Review what information is already known

2) Independent Assessment Review (5 min):
   • provide 10 assessments

3) Interview Questions (30 min):

   1. Did you have a chance to use the assessment?
   2. How do you feel about the home safety assessment?
   3. From a scale of 1-10, how helpful did you find this tool?
   5. Is this a tool you would like to add to your intake session routine?
   6. Did you have a chance to use the Caregiver Strain Index?
   7. What did you think of this assessment?

4) Wrap-up (2 min):

Cool down exercise.
   o “What is one thing that you heard here that was really important?”
   o Thank participants and remind them how the information will be used.
   o Provide a follow-up summary of the discussion

Focus group summary
Various techniques are possible for analyzing the data. An abbreviated process may be sufficient.

At the end of the focus group, the facilitator and assistant moderator debrief, review notes and write down the themes and main points that emerged and were discussed under each question and in general.

Within the next few days, the facilitator and assistant moderator review their own notes independently and then reconcile any differences in their interpretations.
The Modified Caregiver Strain Index (CSI)

By M. Terry Sullivan, RN, MSW, MSN, CMC, Connecticut Community Care, Inc.

WHY: Informal supporters provide the majority of long-term care to chronically disabled older adults. Caregiving has been recognized as an activity with perceived benefits and burdens. Caregivers may be prone to depression, grief, fatigue, and changes in social relationships. They may also experience physical health problems. Perceived caregiver burden has been associated with premature institutionalization and patient reports of unmet needs. Screening tools are useful to identify families who would benefit from a more comprehensive assessment of the caregiving experience.

BEST TOOL: The Modified Caregiver Strain Index (CSI) is a tool that can be used to quickly screen for caregiver strain with long-term family caregivers. It is a 13-question tool that measures strain related to care provision. There is at least one item for each of the following major domains: Employment, Financial, Physical, Social, and Time. This instrument can be used to assess individuals of any age who have assumed the role of caregiver for an older adult. The Modified Caregiver Strain Index is a version of the Caregiver Strain Index developed in 1983. The tool was modified and developed in 2003 with a sample of 158 family caregivers providing assistance to adults aged 53 and older living in a community-based setting (Travis, et al. 2002; Thornton & Travis, 2003). Scoring is 2 points for each ‘yes’, and 1 point for each ‘sometimes’ response. The higher the score, the higher the level of caregiver strain.

VALIDITY AND RELIABILITY: Internal reliability coefficient is slightly higher (α=.99) than the coefficient originally reported for the CSI in 1983 (α=.86). Two-week retest data for one-third of the caregiving sample (n=53) were available and resulted in a test-retest reliability coefficient of .88.

STRENGTHS AND LIMITATIONS: The Modified CSI is a brief, easily administered, self-administered instrument. Long-term family caregivers were not comfortable with the dichotomous choice on the CSI and the modified instrument provides the ability to choose a middle category response best suited to some situations. The Modified CSI clarifies and updates some of the items on the original instrument. The tool is limited by lack of a corresponding subjective rating of caregiving impact. There is no breakdown of score regarding low, moderate or high caregiver strain, so professional judgment is needed to evaluate to total score the level of caregiver strain. The tool effectively identifies families who may benefit from more in-depth assessment and follow-up.

FOLLOW-UP: The higher the score on the Modified CSI, the greater the need for more in-depth assessment to facilitate appropriate intervention. Additional items and further efforts to develop and test a set of subscales could enhance the applicability of the instrument for research and practice. The patient's cognitive status and problematic behaviors should be assessed, as well as the caregiver's perception of role overload or deprivation in key relationships, goals or activities. Family conflict, work role-caregiving conflict, and caregiver social support are also important variables in the overall caregiving experience. Additional work with highly strained long-term caregivers who are receiving little or no formal services is indicated.

MORE ON THE TOPIC:
### Modified Caregiver Strain Index

**Directions:** Here is a list of things that other caregivers have found to be difficult. Please put a checkmark in the columns that apply to you. We have included some examples that are common caregiver experiences to help you think about each item. Your situation may be slightly different, but the item could still apply.

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes, On a Regular Basis</th>
<th>Yes, Sometimes</th>
<th>No</th>
<th>0</th>
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</thead>
<tbody>
<tr>
<td>My sleep is disturbed</td>
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<tr>
<td>(For example: the person I care for is in and out of bed or wanders around at night)</td>
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<tr>
<td>Caregiving is inconvenient</td>
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<td>(For example: helping takes so much time or it’s a long drive over to help)</td>
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<td>(For example: helping restricts free time or I cannot go visiting)</td>
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<tr>
<td>There have been family adjustments</td>
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<td>(For example: helping has disrupted my routine; there is no privacy)</td>
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<td>There have been changes in personal plans</td>
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<td>(For example: I had to turn down a job; I could not go on vacation)</td>
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<td>There have been other demands on my time</td>
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<td>(For example: other family members need me)</td>
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<td>There have been emotional adjustments</td>
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<tr>
<td>(For example: severe arguments about caregiving)</td>
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<td>Some behavior is upsetting</td>
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<td>(For example: incontinence; the person cared for has trouble remembering things; or the person I care for accuses people of taking things)</td>
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<td>It is upsetting to find the person I care for has changed so much from his/her former self</td>
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<td>(For example: he/she is a different person than he/she used to be)</td>
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<td>There have been work adjustments</td>
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<td>(For example: I have to take time off for caregiving duties)</td>
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<td>Caregiving is a financial strain</td>
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<td>I feel completely overwhelmed</td>
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<td>(For example: I worry about the person I care for; I have concerns about how I will manage)</td>
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</table>

[Sum responses for “Yes, on a regular basis” (2 pts each) and “yes, sometimes” (1 pt each)]

**Total Score =**

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## DAVS Home Safety Assessment

### Entrance and Exit
- Light switch inaccessible
- Poor condition of surface leading to doorway
- Threshold height ≥ 1" or more
- Door locks, knobs inaccessible
- Mailbox inaccessible
- Peephole/door view window inaccessible
- Window locks nonfunctioning/inaccessible
- Client doesn’t respond to doorbell or knocking

### General Safety
- Environmental controls & thermostat difficult to reach and read
- Windows, curtains, doors difficult to open
- Emergency numbers not visible or near each phone
- Personal emergency response system not in place
- No installed smoke/CO<sub>2</sub> detectors or in working order throughout the house
- Fire extinguisher unavailable
- Home smells of gas or strong odor
- Kitchen and bathroom piping is exposed
- Areas of concern:
  - Bedroom
  - Bath
  - Kitchen
  - Living, Dining Stairway

### Lighting: Examine lighting level and quality
- Light in each room inadequate
- Light switches inaccessible at doorways for each room
- No lit pathway to bathroom at night
- Areas of concern:
  - Bedroom
  - Bath
  - Kitchen
  - Living, Dining Stairway

### Flooring
- Unsafe floors and throw rugs
- Floors have rips, holes and clutter
- Areas of concern:
  - Bedroom
  - Bath
  - Kitchen
  - Living, Dining Stairway

### Stairways
- No handrail at entry(s)
  - Condition
    - Stairways obstructed
    - Steps uneven/disrepair
    - No light switches at the top and bottom of stairs

### Bathroom
- Toilet paper out of reach from toilet
- Hot water not regulated to prevent scalding
- No slip strips on shower/tub floor and no non-slip bathmat
- Areas of concern:

### Kitchen
- Work areas have poor overhead lighting
- Oven and refrigerator are difficult to open
- Wall and floor storage heights and counter inaccessible
- Client has difficulty transferring food from kitchen to table
- Areas of concern:

### Living, Dining and Bedroom
- Feet do not touch floor when sitting in chair, sofa or edge of bed (to prevent falls)
- Chairs without armrests
- Phone, TV, radio and lights inaccessible from sitting places and bed
- Client requests assistance changing light bulb
- Areas of concern:

### Items of concern in this area require immediate attention
- Client/Caregiver states fear of falling or appears unsteady
- Client/Caregiver states difficulty getting to car/garage
- Client/Caregiver states difficulty transferring in and out of car
- Client has difficulty getting on/off toilet
- Client has difficulty getting in/out of the tub/shower safely
- Stove controls difficult to see and use (to prevent burns)
- Client has difficulty with transitions from sit to stand
- No grab bars installed
  - on tub/shower wall
  - near toilet

*Five or more checked items, consider referring to occupational therapy by contacting client’s physician*
HOME SAFETY AND CAREGIVER SUPPORT TO A COMMUNITY AGENCY

Ashley Becker, OTS & Melanie Hall, OTS
Pacific University School of Occupational Therapy

OUTLINE

- Introduce Washington County Disability, Aging, and Veterans Services (WCDAVS)
- Needs assessment
- Creation of Home Safety Assessment
- Selection of quality of life assessment
- Presentation to staff and volunteers of WCDAVS
- Focus group
- Final product
- Future ideas
WCDAVS

- County agency supporting these populations in the community
- Provides funding for individuals who qualify
  - Respite for caregivers
  - Adaptive equipment in the home
  - Home Build
  - Assistance with connecting to community resources
  - Support groups

NEEDS ASSESSMENT

Deborah Letourneau – Program Coordinator, WCDAVS
Nancy Krusen – Faculty Advisor, Pacific University

- Program Partnership
  - Training at conference
  - Tips for caregivers of dementia
  - Tips for fall prevention
  - Provide in-service to WCDAVS staff and volunteers
HOME VISIT

• Purpose:
  – To determine need and qualification of services
  – To connect people to community resources
• Case managers, staff, and volunteers are usually the first to visit the client in their home environment
HOME SAFETY ASSESSMENT

- Researched existing home safety Assessments
  - Most cost-effective method for fall prevention
  - Most significant for individuals with low vision or at risk due to health problems

(Frick, Kung, Parrish and Narrett, 2010)

DAVS Home Safety Assessment

**General Safety**
- Environmental controls & thermostat difficult to reach and read
- Windows, curtains, doors difficult to open
- Fixed objects not visible or near each phone
- Personal emergency response system not in place
- No installed smoke/CO detector or in working order
- Fire extinguisher unavailable

**Areas of concern:**
- Bedroom
- Bath
- Kitchen
- Living
- Dining
- Stairway

**Lighting:**
- Examine lighting level and quality
- Lights in each room inadequate
- Light switches inaccessible at doorways for each room
- No light pathway to bathroom at night

**Areas of concern:**
- Bedroom
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- Kitchen
- Living
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- Stairway

**Flooring:**
- Unsafe floors and throw rugs
- Floors have rips, holes and clutter

**Areas of concern:**
- Bedroom
- Bath
- Kitchen
- Living
- Dining
- Stairway

**Entrance and Exits:**
- Entrance switch inaccessible
- Poor condition of surfaces leading to doorway
- Door locks, knobs inaccessible
- Mailbox inaccessible
- Phone/viewport window inaccessible
- Window locks nonfunctioning/inaccessible

**Stairways:**
- No handrail at entry(s)
- Stairs unclean/unrepairable
- No light switches at the top and bottom of stairs

**Bathroom (client report):**
- Toilet paper out of reach from toilet
- Hot water not regulated to prevent scalding
- No grab bars installed
- Areas of concern:

**Kitchen:**
- Work areas have poor overhead lighting
- Oven and refrigerator are difficult to use
- Wall and floor storage heights and counter inaccessible
- Client has difficulty transferring food from kitchen to table

**Living, Dining, and Bedroom:**
- Feet do not touch floor when sitting in chair, sofa or edge of bed
- Chairs without armrests
- Phone, TV, radio and lights inaccessible from sitting places and bed

**Consider referring to occupational therapy**
- If the following items are marked
- Client/Caregiver states difficulty getting to car/garage
- Client/Caregiver states difficulty transferring in and out of car
- Client has difficulty getting on/off toilet
- Client has difficulty getting in/out of the tub/shower
- Client has difficulty with transitions from sit to stand
- No grab bars installed

*Five or more checked items, consider referring to occupational therapy*
CAREGIVER QUESTIONNAIRE

- Literature highlights the importance in quality of life (QOL) for caregivers
- Provide WCDAVS with a measure to support the caregivers

CAREGIVER STRAIN INDEX

- Determines the level of strain — a combination of stress and burden that has consequences on caregivers’ overall health
- The index assesses 13 aspects of physical health, family finances, social interactions, time demands, and employment

(Van Exel et. al., 2004)
### Caregiver Strain Index

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes=1</th>
<th>No=0</th>
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<tbody>
<tr>
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<td>It is inconvenient (e.g., because helping takes so much time or it is a long drive over to help).</td>
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</table>

**TOTAL SCORE** (Count yes responses. Any positive answer may indicate a need for intervention in that area. A score of 7 or higher indicates a high level of stress.)

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**PRESENTATION**

- Introduced our IPP to WCDAVS
- Literature review of falls and caregiving
- Review of purpose of assessments
- Presentation and distribution of Home Safety Assessment and Caregiver Strain Index
- Asked staff to trial assessments for 1 month and return to participate in focus group
FOCUS GROUP

• Independent assessment review
• Questions to the group
  – How often did you use the Home Safety Assessment?
  – What do you think about the assessment?
  – How helpful did you find this tool?
  – What do you think of the layout?
  – What changes might increase the likelihood of including this in your intake session routine?
  – How often did you have a chance to use the Caregiver Strain Index?
  – What did you think of the usefulness of this assessment?

FOCUS GROUP RESULTS

Home Safety Assessment:
• Most participants rated the assessment as very helpful
• “Helpful”... “It made me think of things I wouldn’t have looked for.”
• “I never thought about asking that before.”
• “It’s a good tool, it really fits our clients.”
• “Excellent, ... tool.”

Caregiver Strain Index:
• “She and I ended up talking a lot longer than I would have if I didn’t have the form to remind me.”
• “Helped open up the dialogue.”
**FEEDBACK REVISIONS**

- **Suggestions for new items to add**
  - Strong or unusual odors in the home
  - No response to doorbell or knocking

- **Changes to current items and flow/layout**
  - Entrances and exits section at beginning
  - Title of last box changed to “Items of concern in this area require immediate attention”
  - Added comments area to all sections
FUTURE IPP PROJECTS

• Set-up an occupational therapy referral system for home assessments
• Connect client care to the future site of the student OT clinic
• Training at the Caregiver Conference

ACKNOWLEDGEMENTS

❖ Nancy Krusen, Ph.D., OTR/L
❖ Deborah Letourneau, MSW
❖ Amy Vlahos, Aging Services Coordinator
❖ Sandra Rogers, Ph.D., OTR/L
❖ The staff and volunteers of WCDAVS