How Occupational Therapists Engage Adult Clients with Cognitive Impairments in Assessments

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my
knowledge and belief, it contains no material previously published or written by another
person (except where explicitly defined in the acknowledgments), nor material which to
a substantial extent has been submitted for the award of any other degree or diploma of
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Abstract

This qualitative descriptive study explored how nine occupational therapists working in physical and mental health settings, engage adult clients with cognitive impairments in assessments. The multi-disciplinary literature relating to this topic was explored and showed there is a lack of discussion about engaging people with cognitive impairments in health related assessments.

The methodology consisted of a qualitative descriptive design within a naturalistic approach. Semi structured interviews guided by an interview schedule were conducted, digitally recorded and transcribed. Inductive analysis involved coding the data, then grouping codes into similar themes, which were refined through an iterative process. Two main themes emerged from the data with several subthemes in each.

The findings showed that the participants used a complex process and individually developed strategies to engage adult clients with cognitive impairments in assessments. The first theme, called Managing a Complex Process, described the steps the occupational therapists used with clients and families. In this process, the therapists were required to obtain informed consent, prepare for the assessment, consider the impact of having a third party present during the assessment as well as the role of standardized versus functional assessments. The second major theme, called Recruiting Cooperation, addressed how the participants used the relationship with the client to recruit him or her to engage in the assessment. The participants utilized verbal and non-verbal communication skills and also described using their own past experiences. The

therapists' personal attributes played an important role in successfully managing this aspect of the process.

The findings provide a snapshot of the complex processes to engage someone with a cognitive impairment in an assessment and have a number of implications for practice, the profession and further research. In practice, there need to be clear clinical pathways for obtaining informed consent with clients with cognitive impairment. Therapists need to consider developing a variety of strategies to engage this particular client group in an assessment, as one strategy may not work for all clients. For the occupational therapy profession, further research is required on the use of standardized assessments when assessing someone with a cognitive impairment and exploring the difficulties therapists have in engaging clients in assessments that are not occupation based. Lastly, a replication of this study with an observational component and a larger sample size is recommended. In the absence of local and international research, it would be beneficial to explore strategies other therapists are using in other countries.

Chapter One: Introduction to the Study

Introduction

This qualitative descriptive study explores how occupational therapists engage adult clients with cognitive impairments in assessments, within the New Zealand context. Nine occupational therapists working in the public and private sector were interviewed and asked to describe their experiences of engaging adult clients with cognitive impairments in assessments. This included the therapists' account of the processes they used leading up to the assessments, the use of formal and informal functional and cognitive assessments and how the participants developed and used the therapeutic relationship.

My interest in the study arose from my observations over four years as a community occupational therapist, when it was often unclear whether a client with a cognitive impairment had consented to being referred to an occupational therapist for an assessment. Clients are phoned to arrange appointments to visit them at home but often clients decline the appointment for a variety of reasons. From my experience, clients decline assessments due to lack of understanding of the role of the occupational therapist or fear of the consequences of the assessment. For example, I have commonly heard clients say it is a "test" to see if they can remain at home, or at completion of the assessment ask if they have "passed". In the community setting, I have learnt the importance of trying to reinforce the benefits of completing assessments. This includes being able to identify areas of concern, in order to introduce strategies to manage those concerns within the home environment. This study focuses on the ways other therapists

engage adult clients with a cognitive impairment in assessments. It concerns the assessment process, from receiving a referral or recognising the need for an assessment, through to undertaking the assessment with or without involvement from the client's family. It does not address the implications of interventions following the assessment. The terms used in the study will now each be introduced and explored to help clarify the research question, the data and findings and further describe the context of the study.

Cognitive Impairment

Cognition consists of "interrelated processes including the ability to perceive, organize, assimilate, and manipulate information to enable the person to process information, learn, and generalize" (Abreu & Toglia, as cited in Toglia, Golisz, & Goverover, 2008, p. 25). Cognitive function includes the comprehension and use of language, being able to do mathematical calculations, memory recall, perceptual processing, awareness, reasoning, making judgments and demonstration of social skills (Venes, 2005). Cognitive impairments may present as temporary impairments due to acute illness or medication side effects. Persistent cognitive impairments may be due to a number of different diagnoses including neurological conditions such as, cerebrovascular accident (CVA), traumatic brain injury, multiple sclerosis and any type of dementia (Hobson, 2006). This study focused on occupational therapy assessment of clients with persistent cognitive impairments. The ability to engage in the domains of daily routines, tasks and occupations is dependent on cognition (Glogoski, Milligan, & Wheatley, 2006). Impairment in any one of these domains can affect occupational performance in the activities of daily living, making people candidates for occupational therapy intervention (Hobson, 1996). Townsend and Polatajko (2007) note that decision-

making processes can be affected by people's cognitive status, therefore as occupational therapists, how do we engage the client to participate in the assessment?

Engagement in Occupational Therapy

Engagement can be defined as the "the act or state of being engaged" (Concise Edition English Dictionary, 2007, p. 108) and to engage someone is described as to cause him or her to participate. Occupational therapists focus on engaging clients in everyday activities to improve and maintain physical health, remediate disability and encourage adaptive behavior (Creek, 2007). It is essential that clients actively participate in occupational therapy as it increases choice, control over their healthcare, autonomy and responsibility for outcomes (Creek, as cited in Creek, 2007). However, the literature discussed in chapter 2 reveals that those who would benefit most from occupational therapy, such as people with a cognitive impairment, are the most difficult to engage.

Townsend and Polatajko (2007) have also discussed how occupational therapists must enable safe engagement while taking into consideration choice, risk and responsibility both professionally and legally. There is an "ethical commitment to respect client views, experiences, interests and safety" (Townsend & Polatajko, 2007, p. 100) in occupational therapy processes. However, what does this mean when working with clients who have a cognitive impairment that has lead to poor judgment, awareness and decision-making?

Assessment

Prior to completing assessments, treatment or interventions, therapists need to obtain informed consent. This consent process can be increasingly difficult with people with a cognitive impairment who might have decreased insight into their condition, and impaired memory and judgement, thereby impacting on their decision-making process (Hobson, 1996).

In occupational therapy, a particular area of intervention is the assessment or evaluation of the client's capacity to be able to remain in his or her own home (Dimond, 1997). Occupational therapists visit people within the home or see them in the hospital environment to complete assessments, often completing a semi-structured interview, focusing on the person's self care, productivity and leisure activities. From this, further assessments can be completed depending on the client's need. For example, a therapist may complete functional assessments reviewing meal preparation tasks, home environmental assessments or standardized pen and paper based assessments.

Comprehensive cognitive assessments are required to provide evidence of the presence of cognitive impairments and to generate information to use for intervention planning (Toglia et al., 2008). Standardized or formal assessments are those with a specific administration protocol, which compare the client's results to normative data. These types of assessments can assist therapists to determine the presence of impairment or quantify the severity. These assessments are useful as a baseline, and can be re-administered to show a change in condition over time (Toglia et al., 2008). Non-standardized or informal tests are assessments where the therapist chooses what

occupation and how they will assess the client through an observational task. This type of assessment is reliant on the therapist's observation skills and is highly subjective and can be influenced by the therapist's definition of "normal" (Trombly, 1995).

This study will not attempt to analyze which assessment tools should be used when assessing clients who have a cognitive impairment, but rather provide descriptive information of strategies occupational therapists use to engage this client group in an assessment process within the New Zealand context. The findings may reveal that occupational therapists are using different ways to engage people with cognitive impairments in different types of assessments. The significance of the study will now be discussed.

Significance of the Study

This section will present the three most significant reasons for why this study is important. The first is the prevalence of cognitive impairment, the second is the assessment outcomes and how these inform the occupational therapists' decisions affecting people's living circumstances and lastly, the implications of the occupational therapy philosophy and ethics of practice. Each of these will now be presented.

Prevalence of Cognitive Concerns

The prevalence and incidence of cognitive impairment varies world wide. The incidence and prevalence of cognitive impairment in dementia, Parkinson's disease, multiple sclerosis and stroke related cognitive changes will now be discussed.

Frances (2006) reported that as there is an aging population there would be an increase in the amount of services required for people including dementia over the coming years. Within New Zealand, in 2008 there are an estimated 40,746 people with dementia, of this 3.6% are Maori, 3.0% Asian, 1.7% Pacific and 92.7% European/other. In New Zealand it is estimated that there were 12,333 new cases of dementia in 2008 alone. It has been projected that in 2026 there will be an increase in people with dementia to over 74,000 New Zealanders (Alzheimers New Zealand, 2008). In addition, a systematic review completed by Aarsland, Zaccai and Brayne (2005), showed that studies in European and North American populations suggest the prevalence of dementia in Parkinson's disease is 25-30%. In contrast, cognitive impairment affects 45-60% of clients with multiple sclerosis (Hoogs, Morrow & Benedict, 2010). Further, approximately 8000 people will suffer a stroke in New Zealand each year resulting in a long-term disability. Forty five percent of people with an acute stroke have a cognitive impairment and stroke has also been shown to have a link with dementia (National Stroke Foundation, 2009).

The statistics presented highlight the increasing need for support services such as occupational therapy and the importance of being able to engage this client group within assessments if they present with a cognitive impairment, to ensure their safety and independence within the community. This is in alignment with the Health of Older People Strategy to use a "holistic, person centred approach that promotes wellness and participation" (Ministry of Health, 2002, p. 14). This can be achieved by early provision of occupational therapy to assist people to live in their own home longer with or without supports and delay the options of residential care (Dimond, 1997). Older

people have a main role in developing their own healthcare (Ministry of Health, 2002) and occupational therapists promote this with clients who have a cognitive impairment to maintain their safety at home. The role of the occupational therapist starts with an assessment of their functioning in their home.

Further to the Health of Older People Strategy is the Positive Aging Strategy. Occupational therapy assessments can support the purpose of this strategy which is to "promote positive aging across a broad range of sectors, and to improve opportunities for older people to participate in the community in ways they choose" (Health Workforce Advisory Committee, 2006, p. 9). Occupational therapy assessments can identify barriers and/or concerns that prevent this client group from remaining at home and participating in the community. These assessments also contribute to the provision of support services available within the community and promote safety at home to enable clients to live in their own homes longer. The prevalence of cognitive impairment in older people living in the community supports the need for this study. Cognitive impairment can also be associated with mental health diagnoses and some of the occupational therapists recruited to this study worked with and discussed their experience of engaging that population in assessments. The significance of assessment outcomes will now be explored.

Assessment Outcomes

The second significant reason for this study is how occupational therapists work with clients to enable them to achieve their goals by participating in their desired occupations. Occupational therapists receive referrals from geriatricians, general

practitioners and other health professionals requesting assessments of their clients and opinions about client safety and ability to function or ability to return home. Devising ways to achieve an opinion rests on having reliable information about the nature and extent of the difficulty that challenges participation. Assessments are considered essential, to ensure the client is maintaining a level of independence within the community and identifying if supports are required (Harris & Eng, 2004). This research focuses on assessments conducted with adult clients who have impaired cognition, including memory, concentration and attention deficits.

There is a general assumption in occupational therapy literature that people want to live independently in the community and participate in occupations that are meaningful to them. Clients who have cognitive impairments are at risk of not being able to manage everyday activities because of functional impairment related to difficulties with sensory processing, memory, task sequencing and decision making (Bossen, Pringle Specht, & McKenzie, 2009). Other safety concerns include getting lost, falling, risk of burns and abrasions when using stove elements, and medication mismanagement. Occupational therapists may play a role in preventing or minimising these risks with environmental modifications, education of carers or referrals to increase home supports. Older adults who are living alone with minimal family or formal supports are considered to be particularly vulnerable. Occupational therapists therefore need to engage this client group successfully in assessments to draw outcomes that will impact the clients' living situations.

Professional Context: Philosophy and Ethics

Lastly, there are underlying philosophies and models used to guide how occupational therapists work with clients. These philosophies not only exist to explain the world around us but provide a dynamic knowledge base to validate and guide practice, enhance the development of occupational therapy services and identify the uniqueness of the profession (Krefting, 1985; McColl, 1997; Miller & Schwartz, 2004). Underlying models and philosophies assist therapists to analyse and understand occupation, which in turn helps us to know what to do to promote and improve occupation (McColl, 1997).

Townsend and Polatajko (2007) discussed the relationship between client centred practice and enablement. Client centred enablement focuses on a collaborative relationship with the client "to advance a vision of health, well-being, and justice through occupation" (Townsend & Palatajko, 2007, p. 109). A client-centred approach that is widely used by occupational therapists incorporates the following concepts: respect for clients and their families and the decisions they make, client participation in all aspects of care, individualised service and enabling clients to solve their own occupational performance issues (Wilkins, Pollock, Rochon, & Law, 2001). A client centred approach involves the client being given the necessary information to make informed decisions on services that will meet their needs and the assessment results also inform the occupational therapist's decision making (Canadian Association of Occupational Therapists, 1997). However, when occupational therapists work with clients who have a cognitive impairment, it can be difficult to set goals with them and develop interventions in which clients can participate in and to engage them in making informed decisions. This difficulty can be due to the client not understanding the reason

the therapist is visiting or (not understanding) the language used by the therapist when he or she proposes initiating an assessment process.

 Occupational therapy practice needs to be improved in the area of strategies to use when working with older adults who have a cognitive impairment (Moats, 2007). This is due to the client's decision-making ability when the client has a cognitive impairment and has not been declared incompetent. Moats (2007) stated "the simplistic implication that cognitively impaired clients who are not declared incompetent should make their own decisions ignores the murkey complexity of dealing with this population" (p. 95). Despite these communication challenges, occupational therapists need to be careful when engaging clients with cognitive impairments in an assessment process, because their practice is governed by a code of ethics, which will be discussed next.

Occupational therapists adhere to the Occupational Therapy Board of New Zealand (2004) professional Code of Ethics, which protects the client's interests and safety in situations where clients could be put at risk. The New Zealand code of ethics aligns with the other occupational therapy codes of ethics internationally (Ethics Commission, 2006). The purpose of the code is "to inform and protect current and potential consumers of occupational therapy services and to protect the integrity of the occupational therapy profession" (Occupational Therapy Board of New Zealand, 2004, p. 1). The code emphasises respecting "the autonomy of consumers receiving their service, acknowledging the consumers' roles in family/whanau and society, and sharing power and decision-making wherever practically possible" (Occupational Therapy Board of New Zealand, 2004, p. 2). In addition to working "with consumers to

determine goals and priorities" (Occupational Therapy Board of New Zealand, 2004, p. 1), there is acknowledgement that there may be "situations in which consumer choice is overridden, e.g., for reasons of safety" (Occupational Therapy Board of New Zealand, 2004, p. 2) such actions require clear documentation that makes the reasoning process apparent.

Clients' right to refuse services is to be recognised and respected. In relation to consenting to assessments, the Occupational Therapy Board of New Zealand code of ethics (2004) specifies therapists must ensure consumers are able to make informed choices "except where any enactment of the Code of Health and Disability Services Consumers' Rights, or common law provides otherwise, before commencements of any occupational therapy intervention/service" (Occupational Therapy Board of New Zealand, 2004, p. 3). In circumstances where clients have "diminished competence, the occupational therapist shall be guided by the Code of Health and Disability Service Consumers' Rights" (Occupational Therapy Board of New Zealand, 2004, p. 3). Further to this, the code "establishes the rights of consumers, and the obligations and duties of providers to comply with the Code. It is a regulation under the Health and Disability Commissioner Act" (Health and Disability Commission, 2009, n. p.). In appropriate situations, "the occupational therapist shall seek consent from the family/whanau prior to the commencement of occupational therapy interventions or participation in studies or research" (Occupational Therapy Board of New Zealand, 2004, p. 3).

Informed consent is obtained prior to the provision of services, which protects the client's interests and safety. Occupational therapists can assess the client's level of cognitive impairment and how this may impact the client's level of functioning at home and decision-making processes. According to the New Zealand Health and Disability Services statement of Consumers Rights, right seven of the ten rights in the code confer the right on consumers to make an informed choice and to give informed consent to receive health and disability services (Johnson, 2004). Consent is a process involving the client and requiring the occupational therapist to communicate openly by providing full information in a manner that can be understood by the client. This requirement will be discussed further in chapter two.

When using a client-centred approach and adhering to the code of ethics, therapists need to explain the assessment processes to the client and their family, in sufficient detail for them to be able to give informed consent. The principle underpinning this requirement is that occupational therapy needs to be based on client choice, participation in planning, allowing clients to succeed and to take risks and fail (Canadian Association of Occupational Therapists, 1997; Clemens, Welte, Feltes, Crabtree, & Dubitzky, 1994; Law, Baptiste, & Mills, 1995) and being given the opportunity to be assessed. In chapter two, client centred practice will be explored further, drawing on a range of literature.

Research Question

The various considerations outlined above in relation to occupational therapy and a client-centred approach to engaging clients in cognitive assessments led me to pose the following question:

How do occupational therapists engage adult clients with cognitive impairments in assessments?

Myself as the Researcher

The researcher is an integral part of the qualitative research process. It is therefore important I am introduced as the researcher, because my experiences professionally and personally will have an impact on how the research is undertaken. I am an occupational therapist working within a community occupational therapy setting, serving people who live in their own homes and providing assessments and interventions to maximize their independence in the community. As an occupational therapist my aim in carrying out the study was to describe the experience that other occupational therapists have had regarding how they engage clients with cognitive impairments in assessments. I have worked within a variety of settings within the public health system and have observed therapists engaging clients in a variety of formats to complete cognitive assessments. As I have completed further study and research within the occupational therapy field, I have felt uncomfortable with methods sometimes used by therapists and the ways in which clients have explained their decision to consent to engage in the assessment process.

I have experienced clients refusing to consent to occupational therapy home safety assessments. I have felt that I am faced with ethical dilemmas when there are concerns about the client's safety at home and the client declines to participate in an occupational therapy assessment. When speaking to my colleagues they have experienced similar situations. My understanding is that different people develop and use different strategies as discussed in the literature, which will be discussed further in chapter two. I am unsure which strategies therapists use to work with clients and if these strategies are successful with clients who have a cognitive impairment. Given that, in the future, occupational therapists' work in this area is likely to increase, it was appropriate that research was undertaken to gain a greater understanding.

In qualitative research is it important for the researcher to acknowledge assumptions that may be brought to and have influence on the research. By highlighting these presuppositions, it is hoped to limit the effect of potential bias. The assumptions I brought to this study included:

- Occupational therapists have underlying philosophies and intervention approaches to guide practice, in particular client centred practice.

- All therapists use their own clinical reasoning to identify a person as having a cognitive impairment.

- Therapists have a range of skills of how to engage people in occupational therapy.

Structure of Thesis

In this chapter, I have outlined the focus of the study. I have provided the background to the study by defining the key terms used, the three significant reasons for the study were presented and myself as the researcher was introduced. Chapter Two will present a literature review relevant to the research question. The approach used examined the current literature available on this topic and the need for further research is discussed. In Chapter Three, the methodological approach for the study of qualitative descriptive research will be presented. A description of how the study was completed, including participant selection, recruitment, ethical considerations, data analysis and strategies to ensure rigor. Chapters Four and Five reveal the findings of the study. The findings are presented in two themes. The first is managing a complex process and the second is the way occupational therapists use their relationship with clients to recruit their cooperation with assessment processes. Finally in Chapter Six, the findings are discussed in relation to the current literature and recommendations for practice, the occupational therapy profession and further research are presented. The strengths and limitations of the study are also discussed.

Chapter Two: Review of the Literature

Introduction

Clients are routinely assessed by occupational therapists to ensure their safety and independence is maintained at home and in the community. The specific focus of this study is how occupational therapists engage adult clients with cognitive impairments in assessments. In preparation for undertaking the study and throughout the data gathering and analysis phases, a review of the literature was undertaken to determine what is known about engaging clients with cognitive impairment in assessment processes and identify any gaps in this knowledge.

As outlined in chapter one, this review of the literature explores what a cognitive impairment means and the impact of a cognitive impairment on activities of daily living, cognitive assessments, client choice in the assessment process and the implications of obtaining informed consent from someone who has a cognitive impairment. The literature is further examined to look at how therapists use communication skills and clinical reasoning to engage someone with a cognitive impairment in an assessment, and the part played by the profession's commitment to client centred practice. Lastly, I examined the literature for strategies that occupational therapists are currently using in practice and where we stand compared to other professions.

A search of the literature was completed using databases OVID, EBSCO, Medline and PubMed. The search was limited to English and extended out to include the literature from 1980 until present, due to the limited research available. The initial search terms were 'cognition', 'assessment', 'engagement', 'older adults', 'informed consent' and alternate terms of 'elderly', 'evaluation', 'cognitive' and 'memory'. These words gave limited positive hits; other words were added including 'choice', 'awareness' and specific conditions that have known cognitive changes such as stroke, multiple sclerosis, dementia and Alzheimer's disease. Combinations of these words were also used to identify the most relevant articles related to the research question. Theoretical and professional discussions were reviewed and chapters of books that discussed occupational therapy practice. I completed a forward search for research reports that cited literature that I considered informative to the research question. A manual search of reference lists was also completed to ensure the most relevant literature was sourced.

The literature reviewed came from occupational therapy, other allied health disciplines, medicine and psychology, and across a range of health settings. When looking through the literature, there was limited research available specific to this topic. The key themes of client centred practice, client choice and clinical reasoning were the main fields identified and will be presented first. The literature search was further narrowed to specific themes relating to how occupational therapists engage clients with cognitive impairments which include: implications of cognition on occupation and assessment, obtaining informed consent, communication, strategies currently used by occupational therapists and where we stand compared to other professions. The first key theme of client centred practice will now be discussed.

Client Centred Practice

The literature reviewed reported three themes related to barriers when using a client centred practice philosophy with clients. These are aspects of obtaining informed consent, issues related to this, and practising in a client centred way in the presence of a cognitive impairment.

Rogers (as cited in Law, 1998) stated that empathy, respect, active listening and understanding of the person's experiences were key to client centred practice. The Canadian Association of Occupational Therapy has since developed core concepts and guidelines to implement client-centred practice and this concept is now widely recognised in occupational therapy practice (Canadian Association of Occupational Therapists, 1997).

A large amount is written in the literature about client centred practice, which focuses on the literature presented by the Canadian Association of Occupational Therapists (1997), Sumsion and Smyth (2000) and Wilkins et al. (2001). The authors share key concepts on using a collaborative approach, respect for the client, facilitating client choice and involving the client in intervention planning. Falardeau and Durand (2002) build on the literature presented on client centred practice with a shift to using the term negotiation-centred instead of partnership. Within the negotiation process, "there is a search for alternatives, new options, or a wide range of possibilities" (Falardeau & Durand, 2002, p. 139). Falardeau and Durand (2002) presented the benefits of this approach because therapists identified issues to discuss with clients, ensured the client and therapist have the same goal and inform occupational choices. Further research is

required on the application of this model to practice to explore if the negotiation approach is valid and appropriate with clients who have a cognitive impairment.

Despite the amount of literature available on client centred practice and its recommendations, there is limited research available putting this philosophy into practice. The main focus of the literature is based on the therapist and not from the perspective of the client. Wilkins et al. (2001) completed an analysis of three different studies discussing the challenges and barriers to client centred practice. Wilkins et al. (2001) concluded that client centred practice depends on the client's ability to participate and "take control of the situation", and therapists and clients working together for the client to receive "respectful, supportive, coordinated, flexible and individualised service" (p. 78). Given the limited amount of literature available in this area, further research is recommended.

The barriers identified to implementing client centred practice includes therapists' perceptions that client centred practice is too demanding for the client and the therapist having difficulty determining the clients' ability to choose their own goals (Sumsion & Law, 2006; Sumsion & Smyth, 2000). The study completed by Sumsion and Smyth (2000) was a non-experimental, survey designed in the format of a postal questionnaire. The study had a 60% return rate, therefore was based on a small sample of 36 occupational therapists. Further research is required on specific case studies giving examples of how therapists overcome these barriers to client centred practice, and whether the methods presented in the studies are successful or if there are other strategies therapists use.

Research into the specific strategies used to facilitate client centred practice with clients who have a cognitive impairment illustrate that the therapist needs to be knowledgeable of and sensitive to the issues with different client groups (Restall, Ripat, & Stern, 2003). One example illustrated the techniques therapists used during assessment processes that engage and focus specifically on the concerns of the client. Such assessments include the Goal Attainment Scale (GAS) and Canadian Occupational Performance Measure (COPM) (Law, 1998). These tools are shown to be individualised and facilitate engagement of the client in these assessments, because there is an understanding of what is important to the client (Restall et al., 2003). Once therapists have an understanding of client centred practice, the therapist moves into giving the client a choice about engaging in an assessment. Client choice will now be discussed.

Client Choice

Choice is an important component of the occupational therapy process, because choice begins with the "occupational therapy encounter, and is continued throughout the assessment and intervention" (Sumsion & Law, 2006, p. 157). Marteau, Dormandy and DPhil (2001) completed a preliminary study with 66 women to develop a measure of informed choice. The measure is based on informed choice having two main components. The first is "relevant, good quality information" and the second is that the choice "reflects the decision-maker's values" (Marteau et al., 2001, p. 99). The study provided information that shows that people's choice to accept or decline screening is based on informed decisions. Because it was only a preliminary study, further research is required on the validity and reliability of the tool and with a larger sample group. Although this study focused on antenatal clinic appointments, these concepts of

informed choice and decision-making can be applied to occupational therapy practice and all ages.

Marteau and colleagues' (2001) study supports the idea that occupational therapists need to ensure clients are provided with all the information they need to make a choice, including choosing whether to participate in assessments. Choice can be defined to "mean a decision to receive services, or refuse services, or withdraw consent for services" (Johnson, 2004, p. 91). The abilities a person requires to competently make decisions are logically expressing choice, understanding information, appreciating the situation personally and rationally manipulating the information (Grebe, 2007; Venesy, 1994). A number of factors influence people's choice, these include: interests, personal goals and values, awareness of their capacities, the meanings given to different activities and the nature of the choice available (Creek, 2007). Choice is imperative to effective partnership and is linked to the client centred practice process (Sumsion & Law, 2006), as previously discussed. There is an expectation that, within a consumer orientated service; clients are offered choices about timing and interventions. There are pyschological and physical indications to involving clients in decisions about healthcare. These include increased adherence to treatment plans and confidence in healthcare recommendations (Rycroft-Malone, Latter, Yerrell, & Shaw, 2001).

Choices need to be put before clients in an objective manner that provides adequate information to make an informed choice (Fallowfield, 2001). Although there is limited literature available within the occupational therapy field about client choice, Fallowfield's (2001) discussion of clients making decisions about treatment options for

cancer are pertinent. She argued that clients could not participate in decision-making choices unless they have all the right information presented at their level of understanding. Similarly, I would assert that it is important for occupational therapists to present information to clients who have a cognitive impairment in such a manner that they are able to make an informed choice about their assessment options, regardless of their level of functioning. While the interdisciplinary literature discusses client choice, the literature moves to the clinical reasoning therapists use when engaging clients in assessments.

Clinical Reasoning

Occupational therapists make numerous decisions during the therapeutic process to ensure best practice. These decisions and processes can be referred to as clinical reasoning (Watson & Haas, 2010), which Hagedorn (2001) described as involving understanding the client, diagnosing the problem with the client and deciding what to do. It is important to understand that "clinical reasoning in practice means reasoning not only about what is wrong and how to fix it but also about how to engage the patient in that fixing process" (Mattingly, 1991, p. 984).

Clinical reasoning skills are "fundamental in the practice of occupational therapy" (Robertson, 1996, p. 212). Therapists use different aspects of clinical reasoning to effectively interact with clients and modify behaviours and interventions (Boyt Schell & Schell, 2008), attending to the client at three different levels: The physical alignment; the client as a person; and the person as a social being in social, cultural and environmental contexts (Fleming, 1991). Therapists describe multiple types of

reasoning, depending on the clinical problem or encounter and shift from one mode of thinking to another by picking up on cues and responding to these cues when interacting with clients (Fleming, 1994; Unsworth, 2005). Therapists have been shown to analyse the client's problem simultaneously using procedural, interactive and conditional thinking styles (Fleming, 1994). In my experience, interactive reasoning is particularly important when wanting to engage clients with cognitive impairments. This type of reasoning can be described as the therapist trying to understand the client as an individual (Fleming, 1994).

There are a number of purposes why a therapist may want to know more about the client, which include being able to engage the client in assessments and view the disability from the client's perspective (Mattingly & Fleming, 1994). Roberts (1996) discussed interactive and conditional reasoning including building rapport with clients, being empathetic, appropriate communication and therapeutic interaction as professional skills rather than a mode of reasoning. Likewise conditional reasoning can be seen as an "accumulation of schemata to guide practice" (Roberts, 1996, p. 236). Roberts (1996) has argued that those modes of reasoning "are not forms of clinical reasoning but either parts of the process itself or aspects of content" (p. 236). Instead, Roberts (1996) proposes that clinical reasoning is a "universal underlying process of problem solving based on acquiring cues, processing these and proposing a solution" (p. 236). Whether considered to be modes of reasoning or professional skills, these are particularly important for occupational therapists to be able to engage the client within the occupational therapy assessment process.

Unsworth (2005) completed a qualitative study using head mounted video cameras of 13 occupational therapists in physical rehabilitation. The study supported Mattingly and Fleming's work, despite Roberts (1996) questioning it as discussed above. Although the study had a small sample size and was reliant on the therapist's memories, the results build on previous research by Mattingly and Fleming by supporting procedural, interactive, conditional and pragmatic reasoning. From Unsworth's (2005) study, she adds generalization reasoning which is based on "how occupational therapists think in action" (p. 31). However, further research is required to explore this mode of reasoning.

Additionally, interactions with clients directly related to the therapist's values, beliefs and worldwide view (Crabtree, 1998; Fleming, 1991; Hooper, 1996; Mattingly & Fleming, 1994). Clinical reasoning is grounded in the therapist's worldview depending on life experiences and his or her socio economic background; these factors can influence delivery of occupational therapy services and the client-therapist relationship (Crabtree, 1998; Hooper, 1996). The therapist and the client may have different goals, however therapists must create a shared understanding to elicit the motivation required in therapy and incorporate this in the service delivery (Mattingly & Fleming, 1994).

The broad underlying concepts of client centred practice; client choice and clinical reasoning have now been discussed in relation to the literature. Each of these concepts has an impact on how therapists engage adult clients in an assessment. In summary, therapists need to work in partnership with the client, sharing power and the decision making with the client. The next step is the client choosing to engage in an assessment;

therapists need to ensure that all options are discussed at the right level for the client for an informed choice to be made. Lastly, the therapists' clinical reasoning behind assessments and the decisions that are made on a daily basis influence the interaction between the therapist and the client and level of engagement by the client. Due to the limited research available specific to the research question addressed in this study, the literature will now be explored on the specific themes and the components to engage a client in an assessment. This includes implications of cognition on occupation and assessment, informed consent, communication, the strategies that occupational therapists are using that are currently reported in the literature and where occupational therapists stand compared to other health professionals.

Implications of Cognition on Occupation and Assessment

In order to be able to discuss how occupational therapists engage someone with a cognitive impairment in assessments, there needs to be an understanding of what a cognitive impairment means and the effects of cognition on daily living. This is why occupational therapists assess cognition and why engaging someone in an assessment becomes challenging. Firstly cognition will be discussed, followed by the types of assessments used by occupational therapists, and lastly the impact on the client of being unaware of having a cognitive impairment will be considered.

There are many people with neurological conditions such as stroke, multiple sclerosis, Parkinson's disease and traumatic brain injury and other conditions such as depression that have a cognitive component that is associated with difficulties in everyday occupations (Hartman-Maeir, Katz, & Baum, 2009). Some of the causes of these

difficulties are changes in memory, perception, verbal abilities and inductive reasoning. As a result, people experience problems with employing problem solving, managing medication schedules and other activities of daily living. There are difficulties with writing cheques and safety concerns with using stove elements and ovens (Bossen et al., 2009; Wahl & Heyl, 2003). Given the prevalence of cognitive impairment, as discussed in chapter one, and the impact on occupational performance, it is likely that all occupational therapists working with adults will assess someone within this client group in their career (Hobson, 2006). The focus of occupational therapy is to assess clients to determine if they are safe living at home, if they have difficulties with activities of daily living, what the client's strengths and weaknesses are, and what are the ways to support the client in activities of daily living (Hartman-Maeir et al., 2009).

Cognitive assessments are important for two reasons. The first is to provide evidence that a cognitive impairment is present and the second is to gather information for intervention planning (Toglia et al., 2008). There are multiple textbooks describing occupational therapy cognitive assessments, which include the rationale for each assessment, what aspect of cognition each assesses and current treatment approaches (see for example Allen, 1992; McHugh Pendleton & Schultz-Krohn, 2006; Trombly, 2005). The literature does not discuss how occupational therapists conduct assessments or how they go about engaging clients with cognitive impairments in these assessments. There is also detailed information about evaluating cognition and some of the difficulties therapists have in choosing between multiple cognitive assessment options and conducting appropriate assessments (Douglas, Letts, & Liu, 2008; Glogoski et al., 2006; Hartman-Maeir et al., 2009; Small, 2002; Toglia et al., 2008). For example, Hartman-Maeir et al. (2009) have provided a systematic decision making process for the

therapist to have a thorough understanding of the clients' cognitive status as well as what impact the cognitive impairment has on activities of daily living.

Douglas et al. (2008) completed a literature review of 32 assessment tools that therapists use with clients who have a cognitive impairment. They demonstrated which assessments were valid and reliable and showed a wide range of assessments available for use. However, Law (2002) discussed an important point, that when assessing a client with a cognitive impairment, therapists need to take into consideration the characteristics of the client and the environment. An example from Douglas et al. (2007) illustrates this: if a client has a limited attention span, then it would be unrealistic to expect that person to engage in an assessment for a long length of time. For example, selecting a Mini-Mental State Examination (Joint Commission Resources, 2003) to complete with someone who has a limited attention span is a better option than a 60-minute assessment. Because this example highlights one aspect to take into consideration when assessing people with cognitive impairments, there is a gap in the literature describing other strategies that therapists might use to engage clients in the assessment processes.

In addition to ensuring that clients have the capacity to engage in the assessment process, client's awareness of the impact of cognitive problems is recognized as problematic in at least three ways – understanding of their impairments and occupational performance, accuracy of self reporting, and recall of goals and participation in therapy. A person's lack of awareness can be interpreted as the client denying or minimizing the disability (Langer & Samuals, 2008). Firstly, one of the

factors that make assessments of people with cognitive impairments difficult is that they often have limited awareness and understanding of their impairments (Toglia et al., 2008). For instance, Langer and Samuels (2008) completed a quantitative study of 55 clients looking at the specific association of awareness with CVA compared to other non-neurological conditions. The results showed that lack of awareness in occupational performance in CVA may be associated with cognition, however there needs to be further research completed in this field looking at cognitive processes. The findings have limited generalizability due to the restricted sampling criteria that prevented certain client groups from participating in the study.

Secondly, cognitive problems themselves may reduce self-awareness, which has been found to reduce the accuracy of clients with traumatic brain injury in reporting difficulties with activities of daily living (Toglia & Kirk, 2000). Finally, Doig, Fleming, Cronwell and Kuipers (2009) completed a qualitative exploration of 12 people's experiences of client centred, goal directed therapy. They identified that poor self-awareness and memory impairments affected the clients' ability to recall already established goals and participate in therapy. These difficulties with awareness and memory were reported to lead to the inability to recognize the need for assessment and intervention, however the generalizability of the results is limited due to the small sample size and the research being completed in one health setting. The next important component in addition to the current study is obtaining informed consent with a client who has an identified cognitive impairment, which will be discussed next.

Obtaining Informed Consent when a Client has a Cognitive Impairment

Informed consent has been defined as "the legal embodiment of the concept that each individual has the right to make decisions affecting his or her health" (Paterick, Carson, Allen, & Paterick, 2008, p. 313). Further to informed consent is the concept of competence. Competence is defined as the "measure of intelligence, understanding, memory, and judgement relative to a particular transaction as will enable the person to understand the nature of his or her act" (Allen, 1992, p. 7). All people are presumed competent to make an informed choice, unless they have been through the legal proceedings and assessments that declare them incompetent (Grebe, 2007; Johnson, 2004). To ensure the person is able to understand the decision making process and make an informed choice greater care will be required when explanations are made to those with a disability" (Johnson, 2004, p. 121-122).

As an occupational therapist working with clients in the community who have a cognitive impairment, it is challenging when trying to be client centred and needing to obtain informed consent (Hobson, 1996). Further to the New Zealand Occupational Therapy Board Code of Ethics as discussed in chapter one, the United States ethics commission specifies that if the person is unable to give consent, the therapist needs to obtain consent from the person legally responsible for that person (Ethics Commission, 2006). With an increasing demand for occupational therapists to respond to conditions affecting a client's competence, obtaining consent to treatment is important and therapists need to be aware of the factors influencing the legal standards for determining someone's competence (Grebe, 2007). Ethical issues arise in the practice of conducting safety assessments with clients who have a cognitive impairment and whether occupational therapists are equipped for this. Addressing this issue, Foye, Kirschner,

Brady Wagner, Stocking and Siegler (2002) completed a descriptive ethics study, using surveys conducted in large rehabilitation hospitals. The study yielded a 68% response rate and concluded that occupational therapists are not well prepared to manage ethical issues. The researchers concluded that an increase in educational opportunities and guidelines are required for therapists to be able to successfully manage ethically challenging situations.

It seems reasonable to assume that if therapists working in large rehabilitation hospitals experience these difficulties, then therapists working in the community are likely to experience this as well. The importance of communication in occupational therapy will now be discussed in relation to engaging the client in the occupational therapy assessment process and obtaining informed consent. Although the literature discusses informed consent and client choice, one underlying component for both of these concepts is communication.

Communication

Communication is an essential component of the therapist/client relationship. Information between the therapist and client must be "shared in a manner to facilitate communication" (Bloom, 2010, p. 443). When therapists are able to communicate openly about the rationale for assessments, clients may be more willing to engage in the assessment process (Baum & Law, 1997). The specific communication techniques employed by therapists assist them to gain information from the client and build partnerships (Boyt Schell & Schell, 2008). It is important to develop the partnership with the client to be able to create opportunities for client choice. Additionally,

Crepeau (1991) completed a qualitative close study of one occupational therapy treatment session. The study showed therapists need to be able to read the client's verbal and non-verbal cues and to review the session in response to these cues. That study built on previous research that the therapist needs to understand the techniques to "bring about change" in their clients (Crepeau, 1991, p. 1024) as well as techniques or strategies to tailor the intervention to meet the client's needs. It is essential to use a shared language that can create inter-subjective understanding to be able to understand the client (Crepeau, 1991). Without using these techniques therapists are at risk of creating prejudice and having a coercive influence (Bloom, 2010) on the client's decision to engage in the assessment.

Communication is also important because, according to some psychologists, how information is presented to clients will influence their decision-making and how the information is perceived (Moxey, O'Connell, McGettigan, & Henry, 2003; Siegrist, 1997). The first area that will be discussed is framing. This can be described as whether something is presented in a positive or negative frame and how that will influence the decision the client makes. Moxey et al. (2003) completed a systematic review of the literature. That review showed that information presented to clients in a positive manner elicits a preference over choices presented in a negative frame (Moxey et al., 2003). The second important concept in relation to framing is frequency. Siegrist (1997) completed a quantitative study of 105 psychology students. The research showed that to communicate that there is a safety risk when the person is underestimating it, a frequency format should be used (Siegrist, 1997). Researchers recommend presenting information in different ways to the client, for the client to be

able to make an informed choice about the risks and benefits of the intervention (Moxey et al., 2003). This issue is equally important to consider in occupational therapy.

Further complicating the process of gaining informed consent, clients with a neurological condition may present with communication problems such as receptive or expressive aphasia or dysarthria (Sim, 1998). Effective communication with any clients needs to include wide ranging questions, shared decision-making processes, clear verbal information and written information packages and clients feeling that they are active participants in therapy (Stewart, 1995). Communication styles and techniques will impact on whether a client consents to engaging in an assessment. The next section will explore the techniques and strategies currently used by occupational therapists as discussed in the literature.

Strategies Used by Occupational Therapists

Several strategies used by occupational therapists when working with people who have a cognitive impairment are discussed in the literature. Hobson (1996) proposed two strategies. The first is graded decision-making for the client and the second is an advocacy role on the therapist's behalf for practicing in a client centred way. Hobson's (1996) study highlighted the difficulties occupational therapists have in determining whether a client is competent to make decisions and suggested that this may make therapists less confident in using client centred practice with all clients. Hobson's (1996) writing focused on the author's reflections and strategies when practicing in a client centred manner with clients who had a cognitive impairment. Further research is required on the two strategies to assess the reliability and validity of the strategies.

The models proposed by Hobson (1996) are similar to the negotiated model of decision-making proposed by Moats (2007). Hobson (1996) discussed the notion of graded decision-making and advocacy. This is a model used by therapists to guide decision-making. Therapists are often in the position of trying to balance client centred practice when there are safety concerns. Moats (2007) reports that client-defined decision-making is not possible when the client is cognitively impaired or putting others at risk. At this time clients may feel intimidated, coerced, or excluded from the decision making "despite the therapist's commitment to client centred processes" (Moats, 2007, p. 99). That assertion needs to be interpreted with some caution, however, because Moats' (2007) study focused on a small sample size of 10 occupational therapists and relied on self-report. Further research utilising observations was recommended along with further development of the model and its use in practice.

As this review has shown, there is currently limited literature available discussing the strategies available to occupational therapists when engaging clients with a cognitive impairment in assessments. Where occupational therapists stand compared to other professions will now be discussed.

Where Do We Stand Compared to Other Professions?

Because there is limited literature available in the field of occupational therapy in how clients are engaged in assessments, a search was completed across medical and physiotherapy professions. Towle and Godolphin (1999) identified through literature reviews, interviews with family doctors, clients, educators and focus groups with clients

proposed that therapists' "demonstrated capacity to engage in informed shared decision making is characterized by a set of necessary and sufficient competencies" (p. 766). The competencies are as follows: develop a partnership with the client; establish or review the client's preferences for information; ascertain and respond to the client's ideas, concerns and expectations; identify choices; present evidence; make or negotiate a decision in partnership; and agree on the action plan and follow ups. The study found three "objections" to the competencies – "it would take too much time to do all that", "but we [physicians] already do that" and "what about patients who don't want to be involved?" (Towle & Godolphin, 1999, p. 768-769). They only acknowledged barriers to inform shared decision making with all clients due to social, cultural and language barriers, with cognitive limitations being an interesting omission. Based on research findings, Greenhalgh (1999) and Gambrill (1999) endorsed some of these concerns, adding that some clients may not have the capacity to participate in shared decision-making, the lack of consideration of the complexities of clinical work, and that there was no outline of how these competencies should be used in practice. Although this work was published more than a decade ago, there appears to be limited research on this model being put into practice and more specifically how the competencies would work with clients who have a cognitive impairment.

A literature review subsequently completed by Bainbridge and Harris (2005) within the field of medical, physiotherapy and occupational therapy, highlighted how Towle and Godolphin's (1999) competencies can be applied within physiotherapy practice and education. Bainbridge and Harris (2005) reported that "therapists should ask their client what their preferred role is in the decision making process, that is, do they choose to actively participate in decision-making or would they prefer to leave the decision up to

the therapist?" (p. 78). As with previous literature, Bainbridge and Harris fail to address how to complete informed decision making with clients who have a cognitive impairment.

Summary

In this chapter an overview of considerations relevant to engaging adult clients in assessments who have cognitive impairments was presented. Assessing people with cognitive impairments carries ethical obligations and involves specific competencies. There are a number of complex ideas to take into consideration including, obtaining informed consent from someone with a cognitive impairment and using the philosophy of client centred care to work in collaboration with the client. The literature reveals limited knowledge of strategies currently used by occupational therapists and other professional groups, which highlights a need for further research in this area. Due to multiple considerations of engaging clients with a cognitive impairment in an assessment, the methodology for the current study has been chosen to allow for any ideas to surface within participants' accounts of occupational therapy practice. The next chapter will discuss the methodology and methods used to conduct this study.

Chapter Three: Methodology and Methods

Introduction

This chapter will outline the qualitative descriptive research approach used in this study, explain why this approach was selected to answer the research question, and describe the research process. Firstly, the philosophical foundation of the research will be discussed alongside the definition of qualitative descriptive studies. Next the ethical considerations, participant selection, recruitment and data analysis will be described. This chapter will conclude with the strategies to ensure rigor.

When considering this piece of research, as the researcher I needed to consider the philosophical worldview that I bring to the study. The worldview or epistemology of qualitative studies is based on the assumption that people are unable to separate the outside world from their own ideas and perceptions of the world, which means that the researcher is not able to be detached from the research process (Racher & Robinson, 2002). Rather, the knowledge people hold is based on how they perceive experiences and understand their own world (DePoy & Gitlin, 1994). This is consistent with a post positivist perspective which holds that there are multiple views of science and truth and researchers can not be value free because they are influenced by the social, cultural and political contexts (Grant & Giddings, 2002). Four different worldviews have been described; post positivism, constructivism, advocacy/participatory and pragmatism (Grant & Gidding, 2002; Guba & Lincoln, 1994; Patton, 2002). A post positivist worldview underpins this study, in that it aims to describe and explore in-depth a phenomenon from the participants' experiences (Crossan, 2003; Grant & Gidding,

2002). This is an appropriate approach for this study because it aims to describe and explore how occupational therapists engage people with cognitive impairments from the participants' perspectives and experiences of the phenomenon.

As discussed in chapter one, the research question is "How do occupational therapists engage adult clients with cognitive impairments in assessments?" My decision about which methodology to select to answer the research question was shaped by what I found in the literature, which revealed limited consideration and few examples of how clients with cognitive impairments are engaged in the assessment process. The literature reviewed discussed some of the difficulties in relation to informed consent, working with clients who have a decreased awareness and some strategies on how to use a client centred approach with people who have a cognitive impairment. I was unable to find any specific examples about how occupational therapists in New Zealand or in other countries engage clients with cognitive impairments in assessments. Due to the limitations in the literature available, I needed to select a methodology that would generate a straightforward description and comprehensive summary of this topic (Sandelowski, 2000).

Naturalistic Approach

At the outset of this study, my aim was to understand and explain how occupational therapists engage clients with cognitive impairments in assessments. The study aimed at providing an in-depth description from a small selection of people using semi-structured interviews. A quantitative study would not have been suitable, because that required standardized questions, but the literature did not provide sufficient guidance

about what questions to ask (Patton, 2002). Because I wanted to be able to understand and explore the meaning of people regarding a particular problem and a phenomenon that there is little known about, it is more appropriate a qualitative approach was selected (Cresswell, 2009; Strauss & Corbin, 1990). As described by Strauss and Corbin (1990) qualitative research can be broadly defined as any kind of research that "produces findings not arrived at by means of statistical procedures or other means of quantification" (p. 17).

Qualitative research is naturalistic in its approach, meaning that it is based on the assumption that people are not able to separate the outside world from their individual experiences of the world (DePoy & Gitlin, 1994). Guba (as cited in Patton, 2002) first defined "natural inquiry as a discovery orientated approach that minimizes investigator manipulation of the study setting and places no constraints on what the outcomes of the research will be" (p. 39), whereas experimental design studies can be controlled by the researcher. The qualitative researcher completes the study in the naturalistic setting "attempting to make sense of, or to interpret, the phenomena in terms of the meanings people bring to them" (Denzin & Lincoln, 2003, p. 5). It was therefore appropriate that a naturalistic inquiry was used, because the research will take place in a real world setting and the researcher will not attempt to manipulate the data and it will unfold naturally (Hoepfl, 1997; Patton, 2002). This study used semi-structured interviews, which fits within the realms of naturalistic inquiry, and discusses how therapists engage people with cognitive impairments within the day-to-day reality of the environment, with no attempt to control the data (Patton, 2002).

Qualitative Descriptive Research

Descriptive qualitative research is exploratory research and categorized as a level 1-research endeavor (Brink & Wood, 2001). It can also be described as "basic or generic qualitative research" (Merriam, as cited in Caeilli, Ray, & Mill, 2003, p. 3). The research question is predetermined and the outcome of the research will not change according to the data collected or require further information on specific themes like a grounded theory approach. Descriptions depend on perceptions and inclinations of the participants and the researcher. When wanting to describe an experience or event, as the researcher, I needed to collect as much data as possible on what I wished to describe – how occupational therapists engage clients with cognitive impairments in assessments. However, all descriptions elicited from the participants must accurately convey events with descriptive and interpretive validity (Maxwell, as cited in Sandelowski, 2000). Descriptive validity can be described as an accurate account of an event that people observing agree is accurate, whereas interpretive validity is an accurate account of the meanings the participants would agree is accurate (Sandelowski, 2000). Qualitative descriptive research presents the facts in everyday language. It is less interpretive than phenomenology and grounded theory. Phenomenology aims at gaining a deeper understanding of everyday experiences (Patton, 2002) whereas qualitative descriptive provides a description of the phenomena.

I followed Thomas' (2006) procedure of inductive analysis, which fits with qualitative descriptive research. Inductive analysis allows the themes to emerge from the raw data without the restraints of more structured methodologies (Thomas, 2006). Thomas (2006) described five main stages within a general inductive approach to qualitative data analysis. These are: Preparation of the raw data files, close reading of text,

creation of categories, overlapping coding and uncoded text, and continuing revision and refinement of the category system. This process will be discussed in more detail in the data analysis section of this chapter.

Research Methods

This section will discuss the research methods used in the study. This study aimed to describe how occupational therapists engage people with cognitive impairments in assessments. To be able to draw out this information, semi structured interviews were used to collect the data. Semi structured interviews were selected to allow safe disclosure of information and maintain confidentiality. Participants may not of felt able to freely share the same information in a group environment if another method had been chosen, such as focus groups. The participants in the data collection will be discussed and then the processes used to analyze the data. Approval for this study was granted by the ethics committee of Auckland University of Technology (AUTEC) (refer to appendix A). The ethical considerations in this study were; the confidentiality and maintaining anonymity, responding to the principles of the Treaty of Waitangi, doing no harm to the participants, how recruitment of the participants gaining informed consent and the interview process was conducted. Each of these will now be discussed.

Confidentiality and Anonymity

Strategies were put in place to ensure confidentiality and anonymity was addressed. The participants' names, identifying information and participants' employers were removed from transcripts. Pseudonyms were used in this and other reports of the study to ensure participants will not be identified throughout and on completion of the

study. Identifying terms in the transcripts were also removed to ensure confidentiality and anonymity of the participants. The participants did not use names of clients when they discussed within the interviews and were referred to as 'client' or 'patient'.

To further ensure confidentiality, the consent forms were kept in a locked filing cabinet for the duration of the research. Electronic data was kept in a password-protected computer that only I had access to. These methods are supported by Walker (2007) to ensure measures are used to ensure confidentiality of personal information and stored data. The recorded interviews were transcribed by myself as the researcher. Once the data was transcribed and checked for accuracy by myself and by the participants, the recordings were deleted. A copy of the transcripts will remain at Auckland University of Technology for a minimum of six years, after this time the transcripts will be shredded. The ethics committee approved these processes.

Treaty of Waitangi

Within New Zealand there is a formalised agreement called the Treaty of Waitangi, between the British Crown and the Maori people to recognise and protect Maori values, traditions and practices (Hudson & Russell, 2009). In 1998, the Royal Commission on Social Policy identified the Treaty principles of partnership, protection and participation (Hudson & Russell, 2009). When completing this study I have tried to uphold these three principles. During the design phase of the study I consulted with a Maori Research Advisor at one of the District Health Boards. The Maori Research Advisor recommended giving the participants in the study the option to have their responses recorded or the option of the researcher handwriting notes. If there were any Maori participants in the study, to consider using my own "mihi" or formal introductory

speech to begin the interview and offer participants the opportunity to have a support person during the interview as outlined in the information sheet (refer to appendix B).

Participants

The participants of the study were the people who agreed to be part of the research process. According to Patton (2002) and Starks and Trinidad (2007), there are no rules on the sample size in qualitative research; the number of participants depends on the goals of the research and the purpose of the study. Morse (2000) discusses five factors when considering sample size. These are the scope of the study, the nature of the topic, quality of data, study design and the use of shadowed data (Morse, 2000). After discussions with my supervisors, at the beginning of the study, I was aiming for a sample size between 7-12 participants. It was anticipated that this number would generate meaningful findings within the parameters of a master's thesis.

In order to describe how occupational therapists engage adult clients with cognitive impairments in assessments, the participants were required to be registered occupational therapists working with adults (16 years and older) who complete assessments with clients who have a cognitive impairment for example, dementia and/or Alzheimer's disease, stroke, multiple sclerosis and traumatic brain injury. There was a preference for participants with a depth of experience and those working in community settings, because they assess clients in the home situation where they will actually function.

It is important that researchers are aware that they can be viewed as an authority figure, which may create a power differential. Accordingly, therapists who I supervise or who

supervise me were excluded from the study, because this might have created a vulnerable working relationship or interfered with the research process. Subjects may feel uncomfortable and it is essential for the researcher to ensure an environment of confidentiality and unconditional acceptance is present (Taylor & Kielhofner, 2006). Maintaining professional boundaries was also important within the research. Because this research drew from the experiences of occupational therapists, it was important to minimise the concerns of the participant if they did not understand the limits to the researcher's role (Taylor & Kielhofner, 2006). Due to the nature of the study the participant and the researcher needed to be able to have a conversation style interview, so participants needed to be fluent in English. The Occupational Therapy Board of New Zealand has a requirement that occupational therapists are proficient in English if that is not the therapist's first or home language (Occupational Therapy Board of New Zealand, 2004). It was therefore assumed that all prospective participants met this criterion.

Do No Harm

It was not anticipated there would be any risks or discomfort to participants during the interviews. The process of interviewing was seen as being no different to verbalizing reflective practice. However, as with any interview where people's thoughts, feelings, knowledge and experience are opened up for discussion (Patton, 2002), there was a possibility that participants might discover things that they did not know prior to the interview. This risk existed even though the process of the interview was designed to collect data and not to change a participant's practice or attitudes (Patton, 2002). Appropriate measures were put in place so that, if during the course of the interview I felt there was a breach of the Occupational Therapy Board Code of Ethics, the manner

in which I would respond was outlined in the information sheet given to participants (refer to appendix B).

Recruitment

Nine participants were recruited by convenience sampling. This is discussed in the literature as being a fast, convenient, and a common sampling strategy (Patton, 2002). Three strategies were used through the sampling process. Firstly, the researcher completed a 5-minute presentation to the community occupational therapists at a regional District Health Boards meeting informing the group about the study and giving them the opportunity to identify themselves as people that would be willing and available to participate in the study (Carpenter & Suto, 2008). Through this method only one participant was recruited for the study.

The second strategy was through one person advertising the study through the district health board where she was employed and neighbouring health board colleagues and to the private sector. Responses from both of these methods were received and followed up with the information sheet. The researcher contacted potential participants to give further information, check against inclusion criteria and collect demographic information. Through this method three participants were recruited.

The third strategy used was snowball sampling. This method was also utilised to capture potential participants who had the relevant knowledge and experience to provide "information-rich" data to the study (Patton, 2002). This strategy was completed by asking the participants if they knew others who may be interested in

participating in the study (Carpenter & Suto, 2008). This was the most fruitful form of recruitment for the study, with five participants meeting inclusion criteria and consenting to take part in the study.

Informed Consent

Informed consent is described by Conneeley (2002) as the voluntary agreement to participate in research based on the understanding of the nature and purpose of the research. All potential participants who indicated they would like to participate in the study were given an information sheet prior to providing consent (refer to appendix B). The participants had an opportunity to ask questions to ensure they had all relevant information available to them prior to giving written informed consent, which was at the beginning of the interview (Patton, 2002) (refer to appendix C). Ethical issues arise with obtaining informed consent when conducting a study on a vulnerable population such as people with cognitive impairments (Hammell, Carpenter, & Dyck, 1997), however this study focused on the occupational therapists who have been involved in the client's care and not the client themselves.

Demographic Data

Demographic data was collected from the participants who indicated they were willing to participate in the study (refer to appendix D). This information was collected prior to the interviews to ensure the participants met the inclusion criteria for the study. If there had been a large number of therapists meeting the inclusion criteria I had intended to use this information to ensure I captured a diverse range of experience and backgrounds from the participants. The demographic data included the name, gender, ethnicity,

practice setting, years of practice in this setting and previous settings, and whether the therapist used formal or informal assessments with clients who have cognitive impairments.

Of the nine participants, there were three males and six females who worked in the public health sector in physical and mental health settings. One of them also worked in the private sector. The participants had a range of experience in different areas including community physical health, inpatient rehabilitation, acute medical (Tara, Tracey, Adele, Ken, Candice, Sydney) and community mental health, inpatient mental health and one in the residential mental health setting (John, Edward, Sarah). There was a range of years of experience in the sample varying from 3 years to 29 years of practice, the average being 7 years. None of the participants was a new graduate occupational therapist.

Interview Process

Semi structured qualitative interviews were used as the primary means for data collection. Each interview lasted between 30 and 60 minutes. Recruitment was discontinued after the ninth interview as sufficient data was collected and no new information was emerging. An interview question guide was used to ensure that similar information was obtained from each person (refer to appendix E) and because there was no indication from the literature on what questions would be most appropriate. Some of the types of questions used are listed below:

- *Can you tell me about a time when an assessment has not gone according to plan…or/gone unexpectedly well?*

- *Tell me about a time that you had difficulty engaging a person who has a cognitive impairment? What did you do? What did you say?*

The question guide was developed around the occupational therapy process, which is a familiar process, known by all occupational therapists. The process describes the therapy continuum from the first encounter with the client to discharge from the service. By using semi-structured interviews, the focus of the interview is contained however, I was able to probe and explore the participants' responses depending on their experiences of working with people who have a cognitive impairment (Hoepfl, 1997). As the researcher I needed to present myself as a listener and asked the participants to give their experience of the phenomenon. Probing questions were utilized to allow the participant to elaborate on responses or clarify information (Starks & Trinidad, 2007). Some of the examples of the probing questions are listed below:

- *What made you choose to do that?*

- *Was there another way that you would have done that if it happened again?*

- *Can you tell me more about that?*

- *What did that mean for you?*

Interviews were arranged with each participant at a time and a place that was convenient to them. Only one participant chose to not have the interview completed at there work place and this was subsequently completed at Auckland University of Technology. The possibility of a 20 minute follow up interview had been indicated on the information sheet, however this was not required because the information was clearly captured on the interview audio tapes and was able to be transcribed.

Each interview was recorded on a digital recorder. The interviews were then downloaded to the computer and transcribed verbatim. The transcripts were checked against the recorded interview for accuracy a number of times. Each transcript was then sent to the participant to be checked for accuracy. Printed transcripts were kept in a locked filing cabinet. The digital recorded files were deleted after transcription.

Data Analysis

In qualitative research, data is analysed by interpreting words rather than numbers and understanding meanings, processes, people and their thoughts through interpretation (Lysak, Luborsky, & Dillaway, 2006). Qualitative data analysis can be a complex process. One form of data analysis used in the beginning stages was inductive analysis (Patton, 2002). As previously discussed Thomas' (2006) five stage general inductive approach was used as a guide for data analysis. The raw data being placed into logical and meaningful categories to communicate the interpretation to others (Hoepfl, 1997), culminating in the process described in the section below.

The first stage in the general inductive approach is to prepare the raw data. After each interview, the data was transcribed and checked for accuracy by the participant and myself and then each interview was printed out on plain paper ready to be analysed.

The second stage is close reading of the text. Because I had transcribed and checked the interviews, I was very familiar with the content. However, I continued to read through the data to be able to gain a thorough understanding of the main messages within the data.

The third stage is creation of categories or themes. In this stage the main themes are identified. According to Thomas (2006), "the upper level or more general categories are likely to be derived from the evaluation aims. The lower-level or specific categories will be derived from multiple readings of the raw data" (p. 241). I went through each transcript coding sections of the data from phrases and meanings in specific texts. I then cut and pasted excerpts into separate word processing files to form each category.

Initially the categories were broad; for example communication, strategies currently used, role of advocacy, psychological impact, standardised and non-standardised assessments and the role of the family. These categories showed themes and ideas around why therapists completed assessments, including assisting people to return home and what the results of the assessments mean for the client. After discussion of the initial categories with my supervisors the interpretation evolved, looking at why the participants did what they did to get a real reflection on the data collected. The general categories became more specific and aligned with the occupational therapy process and clinical reasoning. The more specific themes included consent, the type of assessments the participants used, involvement of the family and the client-therapist relationship.

During the analysis process, at times I stepped away from working with the data to be able to reflect on the information collected and gain a better understanding of what the

data means. During these times, I worked on other chapters and continued reading the literature.

The fourth stage requires the researcher to look at overlapping coding and uncoded text. Thomas (2006) identified one of the key differences between quantitative and qualitative studies is the analysis in qualitative studies, the text may be coded into more than one category and a significant amount of text may not be assigned to a category because it may not be relevant to the study. In situations when a data excerpt could have been in two different themes, it was sorted into the theme with which it most strongly aligned. There was an amount of text that was unassigned because it was not relevant to the study.

The fifth stage was continuing revision and refinement of themes. Once I was happy with the themes that best represented the data, I labelled each and wrote a description of what it meant. Appropriate quotations that demonstrated the categories were selected. Each theme also included contradictory points of view to strengthen the theme and demonstrate its meaning.

Initially, approximately 27 categories were developed which, upon discussion with supervisors, was considered too many. Over the course of the data analysis and refinement of categories, many of these were merged with similar categories and by developing subcategories. The final result was two main themes: managing a complex process that occupational therapists used and how occupational therapists used the relationship to recruit participation in an assessment. Within these two

themes, there are several subthemes, which will be discussed in the following chapters.

Strategies to Ensure Rigor

Rigor is an important component of any qualitative or quantitative piece of research. This process "strengthens the arguments researchers make when attempting to demonstrate the significance of findings" (Ryan-Nicholls & Will, 2009, p. 70). Caelli et al. (2003) discussed how qualitative rigor began with efforts to be equal to quantitative research. For this study I utilized Lincoln and Guba's (1985) four criteria to demonstrate rigor, as discussed in Finlay and Ballinger (2006). These four criteria focus on credibility, dependability, confirmability and transferability. These criteria were used to make sure the research was carried out thoroughly and carefully and ensured trustworthiness (Finlay & Ballinger, 2006). Each of these will be individually discussed.

Credibility

In all qualitative research, multiple methods of data collection are used to strengthen the credibility of the research findings. Credibility of the research aims to demonstrate the information is described as accurately as possible (Krefting, 1991). Credibility depends less on the sample size than on the quality of the data.

The first method I used to achieve credibility was to use member checking. The transcripts were returned to the participants to check the data collected was accurately captured. The second strategy was to use more than one researcher, which allowed for

the data to be enriched from another perspective (Hammell et al., 1997). The data was reviewed by my supervisors to gain multiple perspectives and this process also functioned as a peer review. I independently coded the data and certain sections were checked against our shared understandings. My supervisors asked for my presentation of the data, to check the credibility of my analysis. These regular discussions allowed them to challenge my thoughts and ideas, kept me true to the research process and stimulated a deeper reflexive analysis (Finlay, 1998). That reflexivity was enhanced by the fact that the topic of the research project is something that interests me. Finlay (1998) warned that as researchers our behaviour, reactions and assumptions can affect the research, despite attempts to be non-judgemental, and that researchers reactions and responses can affect the participants (Finlay, 1998). I needed to be able to ensure I became aware of my assumptions, expectations, emotions and unconscious responses. Finlay (1998) emphasised the importance of reflexivity in any research because lack of it could undermine the validity of the research.

Transferability

The transferability of the findings refers to the degree to which the qualitative findings can be generalized or transferred to another setting or context (Hoepfl, 1997). Curtin and Fossey (2007) asserted that "in general qualitative approaches do not claim to be generalizable, a claim often made of quantitative approaches" (p. 9) to measure external validity. As discussed by Guba and Lincoln (as cited in Hoepfl, 1997), the researcher cannot determine whether the findings of qualitative studies will be applicable to new situations. Completing a thorough job of describing the research context and assumptions can, however, enhance transferability. This was done by providing information about the participants' demographics, the setting and a description of the

processes used within the study. The reader will then be able to make comparisons regarding the information presented and whether it can be transferred to another context/setting (Curtin & Fossey, 2007; Patton, 2002).

Dependability

Dependability is the idea that there is a need for the "researcher to account for the ever-changing context within which research occurs" (Trochim, 2006, n. p.). As the researcher, I am responsible for describing the changes that occur in the setting and how these changes affect the research. The literature discusses an enquiry audit to enhance dependability (Finlay & Ballinger, 2006; Guba & Lincoln, 1994; Hoepfl, 1997; Seale, 1999). Campbell (1997) explained that an inquiry audit is the "steps of the research one verified through examination of such items as raw data, data-reduction products, and process notes" (p. 130). In this study, this was achieved by providing full and accurate descriptions of the research process, methodology, how the information was gathered and the data analysis process.

Confirmability

Confirmability is referred to as objectivity in quantitative research and is the degree to which the research can be confirmed or corroborated on by others (Trochin, 2006, n. p.). Enhancing confirmability was achieved by keeping an audit trail of the raw data, analysis processes, and notes from member checking and drafts of final reports, which can all be seen as confirmable.

Summary

In this chapter, I have discussed the qualitative research approach used in the study. Qualitative descriptive design was defined and discussed as the most appropriate design to complete this study because it will describe participants' experience of an event about which there is little known. The participant selection and criteria were discussed along with the ethical considerations and methods to ensure rigor in the study. In the next two chapters I will present the findings of the data analysis as described in this chapter.

Chapter Four: Managing a Complex Process

Introduction

This chapter and the next will present the findings of this study, which set out to explore how occupational therapists engage adult clients with cognitive impairments in assessments. When analyzing the data from the interviews two major themes arose: Managing a Complex Process, which addresses the steps the therapists use to engage the client in an assessment and Recruiting Cooperation, which is the means by which the therapists attempted to achieve that.

The perspective used to present the analysis in both chapters is a conceptual framework aligned with Mattingly and Fleming's (1994) procedural and interactive reasoning. Procedural reasoning encompasses the steps in the assessment process from meeting the client to determining who is present during the assessment. Interactive reasoning addresses the participants' efforts to establish and preserve a positive relationship with the person who is being assessed. The alignment of the analysis with Mattingly and Fleming's work was not pre-determined; rather it was discovered as themes and subthemes were refined and the distinction between the things the participants do to organize the assessment process and what they do to elicit the client's engagement was recognized.

The theme presented in this chapter of Managing a Complex Process refers to the client's engagement in occupational therapy assessments. The chapter has four

subthemes, which will each be discussed. The path the occupational therapist takes to engage the client in the process will be presented systematically from the first encounter with the client, where informed consent needs to be obtained to the therapist needing to be prepared prior to engaging the client in the assessment. The steps to initiate the assessment process will follow this. Through the assessment process the impact of having family members or other staff members present at the beginning and during the assessment is discussed. In chapter five, the findings that reveal the participants' focus on the therapeutic relationship and recruiting the client's cooperation will be discussed. The process starts with gaining informed consent, which will be presented first.

Informed Consent

The findings of the process for obtaining informed consent are split into two sections. The first is the practical steps and the second is the difficulties encountered when the therapist thinks the client is not capable of giving consent. Prior to contact with occupational therapy services and to enable engagement in an assessment process, the occupational therapist has the responsibility to obtain informed consent from the client. The participants worked across different physical and mental health services and there were a number of different ways consent was obtained.

No participant, whether working with inpatients or clients living in the community, obtained written consent to complete an assessment with the client or family. The main format was verbal consent, where the therapist explained the role of occupational therapy and provided information about why the assessment needed to be completed.

Candice discussed the legal requirements in documenting the informed consent she
obtained:

> *I am always very careful to write in the notes that I gained verbal*
> *consent under the 'S' part of the SOAP notes. And because he didn't*
> *have language difficulties it wasn't that difficult because he answers*
> *your questions so it implied consent.*

Candice illustrates utilizing clinical note writing framework, 'SOAP' notes, as one
format to document consent being obtained. No other participant gave a specific
example of the format used to document consent in the clinical notes. Candice
highlights there can be difficulties when obtaining informed consent when there are
communication difficulties and the client is unable to articulate or understand to give
consent to the assessment.

In physical health settings, the participants described explaining their role to the client
before obtaining consent to engage in any type of assessment. Sydney discussed trying
to give a simple explanation.

> *I introduce myself to the patient and we talk about the fact that that's my*
> *purpose and my role is about looking at what needs to happen to help*
> *them do normal things that they want to do. Um, so that and I keep that*
> *quite simple.*

Sydney showed giving the client a simple understanding of the purpose and role of
occupational therapy at a level that was suitable for the client to understand. By doing
this Sydney ensures the client can make an informed decision and give consent. The
description of the role and purpose is presented to the client by looking into the future
and what the assessment outcomes will achieve.

Further illuminating the process of gaining informed consent, Ken described his first

encounter with a client. Ken described his knowledge of how challenging it can be to

obtain consent to engage in the assessment. In the example below, he discusses the

language that he uses when explaining to the client that he wants to complete a

cognitive assessment. The language used is different from how Sydney presents the

information. Sydney uses a simple format compared to Ken, who has used words such

as '*executive functions*', which the client may not understand. As Ken describes:

> *I remember doing a LOTCA, just Lowenstein's OT Cognitive Assessment, and there was verbal consent at the beginning and [I] told the patient "There has been some concerns from your family about how you were coping at home, especially with your higher level tasks, like your executive functions", and explain that further by saying, "The family have been concerned you have forgotten a few things on the stove before um, and you don't remember your appointments as well as you used to". The patient agreed that way with me and I said "I want to do this assessment to pin point what was difficult for you at, where we can both problem solve to help you out". Um, and got verbal consent from there. Yeah, I guess that way the patient knew what I was doing, why I was doing it and how it related to this specific situation. Um, and so it was much easier to engage them in the actual assessment and later on treat the process, from explaining at the beginning.*

Ken has considered what precipitated the assessment by using specific examples of

functional tasks at home that are concerning the family, such as with using the stove and

forgetting appointments. By doing this, Ken has taken the onus away from him and put

it on the family. With focusing on specific functional tasks, Ken has shown the client

how the assessment is related to everyday life, what the assessment is for and the client

can then make an informed decision about engaging in the assessment process.

Unlike Sydney and Ken, who sought consent from the client who would be assessed when they first met, Adele discussed obtaining informed consent for a community-based service prior to visiting the client at home. There are expectations that clients will engage with the programme and consent again at the first visit when the role of the occupational therapist is explained.

> *We usually get that [a consent to initiate the service] on the phone before we go out, so you know, do you want the service, it's not a compulsory service, you have been referred to us. Are you happy for us to come in and visit you? Um, you know we do expect you to be at home and to follow it". Some people find that they do want the rehab, but then when we start coming in, it is just too much and they are just not ready for it yet, they would like a period of rest. Generally the first couple of visits will indicate that. But yeah, we get the consent before we go out, and then when we go out we explain the service again. I will explain my role as the OT, and um, and generally if you know they are happy to continue that is a consent and I will document it.*

Adele also shows that there is no obligation for the client to continue with the service provided from speaking on the phone after discharge from hospital and once the occupational therapist has visited and the role has been explained. Adele explicitly states there is no obligation to continue with services once the client is at home, thus emphasising client choice in her consent process. The client is gauged on his or her willingness to participate and consent is assumed from this and documented. Even after consent has been elicited, she monitors the client's response to occupational therapy to ensure appropriate timing of services.

Although Adele's example is in a physical setting, in one mental health residential service, consent is assumed based on the client agreeing to engage with the service.

> *Consent is kind of, in some ways assumed in the way I am working, in the way our service is structured and because she is living with us, so really it was just a conversation, there were no formalized forms.*

This response was not typical in that no other participant interviewed discussed the process when the client is living where the service is being provided. Because this was the only participant who had live-in clients, I was unable to establish if this was a typical response.

A commonality across the accounts presented this far is that the therapists discussed speaking directly with the client about consenting to engaging in an assessment. However, what happens when the client is in a different town and requiring an assessment? Tara discussed the difficulties of gaining consent when there were time constraints within the service and extended travel time to complete the assessment.

> *I wasn't in the position to be able to go up there and meet them prior to the assessment, so the key worker explained to her what was going to happen and also explained to the husband what would be happening.*

Tara demonstrates the role that key workers can play in a mental health setting with such processes as informing the client and family about the assessment. In this example, it seems that explicit consent has not been sought from the client or husband; rather the key worker has relayed information from the therapist to the client. There is a sense that in not refusing the assessment and not opting out of the services, a tacit consent is assumed. In contrast to Tara's account, Edward's report of the involvement of a key worker explicitly addressed the consent process and how consent had been obtained. Edward explains.

> *He had already given informed consent I think verbal informed consent to his key worker for the assessment to take place. As well as it had been discussed with his supported accommodation provider that he would be undertaking an assessment, necessary as part of a 3 monthly review, so it was really only verbal consent.*

These examples from Tara and Edward reveal that some clients consent via the key worker to engage in an assessment with the occupational therapist and not directly with the occupational therapist in the first instance. In Edward's example, he thought consent had been sought highlighting the importance of inter-professional communication. Information needs to be communicated between professionals and on to the client and family. In the role of the key worker, these examples show it was necessary to have an awareness and understanding of the occupational therapy role. However, information needs to be shared appropriately and consent sought from that information. Data was not collected on how this form of consent was obtained. The therapists make an effort to ensure that clients with cognitive impairment receive face-to-face information from someone they know, whether it is an occupational therapist or the key worker. The information appears to focus on pragmatic concerns of what the assessment will involve or that it is part of a regular review rather than what the assessments and associated outcomes mean for the client.

These accounts highlight that there are often difficulties in being able to obtain informed consent from someone who has a cognitive impairment. So far the practical difficulties are shown by the differences in explaining the role and purpose and clients consenting to services as well as disciplines. There are concerns with limited time affecting the possibility of obtaining consent directly from clients living some distance

away from the service base and the role of the key worker in mental health settings, which has shown the therapist assuming consent has been sought.

The next section will present the difficulties related to obtaining consent when the therapist thinks the client is not capable of giving consent. When therapists experienced difficulty obtaining consent from the client for an assessment, it was often a member of the family who gave the consent or the family was informed of the need to complete a cognitive assessment. Participants such as Ken found that by having the *'family on board'* when obtaining consent for assessments, the message could be communicated more effectively to the client by creating a collaborative approach. With clients who have arranged for someone to hold an enduring power of attorney, one important component is the role that person has when there are concerns around competency and safety of the client within their home. Ken described his experience of this when he said:

> *Specifically for informed consent, if a person doesn't give verbal consent, you can speak to their next of kin, and I normally do check who has enduring power of attorney and if they [the client] are refusing I will speak to their person with the enduring power of attorney to say. 'This is what we need done in order to decide if the person is safe at home, what type of supports will need to be put in or do we need to look at residential placement if they are posing a risk to themselves.'*

This example from Ken illustrates the differences in what information is presented to the client compared to the next of kin or the person holding enduring power of attorney. Ken's example also demonstrates how the clients wishes can be overruled by the power of legal situations where competence has been previously determined. As previously shown by Sydney and Ken, the information is presented to the client in terms of functional tasks and explaining the role of occupational therapy. In this example from

Ken, the information is presented as what the therapist needs to make a clinical decision on the client's safety and amount of support required at home.

Further to the process of eliciting consent from a client with enduring power of attorney as mentioned by Ken, Sydney discussed her experience with completing the assessments required when there is action being taken through the legal system because there is no appointed enduring power of attorney.

> *Quite often it happens here in this ward that we have patients who come in who are no longer competent to make decisions for themselves and who don't necessarily have an enduring power of attorney and we have to take action through the court and they have been here for weeks on end and that's been quite a challenge to get the standardised assessments necessary for the courts to be able to actually make their decision. I have had more success to some extent than psych[iatric] liaison has, simply because we have had to do the practical stuff and have got more time to develop a rapport with somebody.*

As Sydney described, some assessments are essential for legal proceedings and determining the direction of care and medical involvement. These situations present challenges in obtaining consent and a client engaging to complete the standardized assessments. Sydney described the benefit of having more time to build rapport based on trust, which fosters voluntary consent, compared to psychiatric liaison services, which are enforced from the judicial system. Sydney also described the difference in the occupational therapy role with completing more functional tasks with these clients and the success of this. This is similar to Edward's experience of clients not fully understanding what they are consenting to and his need to develop the relationship with the client. In order for the client to understand the rationale behind why the assessment is required and to gain voluntary informed consent, there needs to be a trusting relationship. Edwards explains.

> *It is difficult to give consent if you don't fully understand what it is that you are consenting for, um, however with his best interests in mind, we were looking to do an assessment that would promote um, him towards a better outcome in terms of his recovery with both mental illness and a cognitive disability.*

Edward shows that as a therapist he wants to do no harm and work towards seeking a positive outcome for the client from engaging in the assessment. This is reliant on the therapist having an understanding on the client's short and long term goals and planning interventions to meet these goals.

One difficulty therapists may experience when engaging a client in an assessment is the type of language and phrases used. The participants were able to describe the type of language that they used when obtaining informed consent prior to undertaking an assessment. Sarah described her experience of the differences between using words such as *'understand'* and *'demonstrate'*.

> *Yeah, I think I like to use the word understand. You know "I would really like to understand, what this is like for you, I would like to". Um, I guess it is easier sometimes to say what I don't like saying as well. You know, I don't like saying to a client "You need to demonstrate this to me so I can go and tell your clinical team that you can live independently". You know, I very much like the, "Tell me what this is like for you, I want to know your experience", um, and "I'm hoping this will help me advocate for you and work with you when you are going to the clinical team saying this is what you want", um, yeah.*

The example above shows that the language used by the participant plays a significant role when obtaining consent. If the client is to feel that the assessment is about understanding their experience the client is more willing to engage in the assessment. This is an example of interactive reasoning for the therapist to get to know the client as a person, rather than just their disability, and the therapist understanding what will

motivate the client to consent to an assessment. This will be discussed further in chapter five. Sarah also highlights the language she does not like using, which shows to prevent creating a partnership with the client or creating a sense of a shared understanding. Sarah uses language that establishes an alliance with the client, signalling her role as an advocate for the client to promote his or her goals within the team.

Another example of language playing an important role in the engagement process was when Adele described her use of the word *'screen'* instead of using the term *'assessment'* when communicating what is involved with engaging in the occupational therapy assessment session.

> *I never call it an assessment; I always call it a screen. And it's not to, it's not a pass or fail. I always say "It's for my benefit because it gives me an idea of what to work on with you, so it's more of a guide for me", um, and you can generally pick up as soon as you introduce the screen you know to them if they are not comfortable with doing it or if they are nervous or those sorts of things. What I try and do is avoid saying that I am going do an assessment on you in three session's time, because then they build it up and build it up and then they are just a bag of nerves. So it's always a screen.*

Adele's example demonstrates how as the therapist she used words to not cause undue worry or stress which could impede the assessment or skew the results of the assessment. This is different from how Sarah presented a partnership with the client; Adele indicates the assessment is to benefit the therapist rather than the client as a means of using the results for intervention planning. Another contrasting example is illustrated by Candice who used the words *'test'* and *'pass/fail'* rather than language to understand the client or advocate for the client as mentioned above by Adele and Sarah.

I can just say, "I have come to give you some exciting you know tests and if you pass you get to go home" you know, and they don't mind, but it depends on the level of formality and how you judge it. Normally it would just be very formal, "oh I would just like to do a test [of] your memory and attention". I never really say I want to do a cognitive assessment because I figure that most people don't really know what cognition means, so I just say "I would really like to do some tests of your memory and attention, and just see if anything has happened as a result of the stroke. Do you mind if we do that?"

Candice demonstrates that the relationship with the client dictates how initiating the idea of an assessment is introduced. Candice has presented the assessment in a jovial manner by using the word *'exciting'*, which is a contrast of how the other participants described their experience of initiating the assessment. This is different to whether a formal or informal approach is used and reliant on the therapist's ability to judge which approach is most appropriate. Candice acknowledges the client may not understand the word 'cognition' so selectively chooses the language she uses for the client to understand.

In summary, the information presented above demonstrates that the participants were aware of the need for a consent process. That process has shown to be variable in its formality and at times taken for granted, being shaped by the context and with differences between inpatient and community settings. There is awareness that being assessed may provoke anxiety and that people have an invested interest in the assessment findings. Therapists select the type of language that they use and this varies between each person and is dependent on the client-therapist relationship. The next subtheme of preparation for the assessment will now be presented, which is the next step once informed consent has been obtained.

Preparation

This section discusses how the participants prepare to conduct an assessment, which has two elements. Firstly, the difference preparation makes to whether clients agree to engage in the assessment and secondly, the difference preparation makes to how smoothly the process is for the therapist.

The participants in the study were from two different settings. These were the mental health and physical health settings with inpatient and community within these. In all areas, the importance of preparation prior to undertaking an assessment was discussed. Consideration needs to be given to the relevance of the assessments therapists are selecting to engage clients in and what would happen if the therapist were not prepared. The factors influencing the use of formal assessments versus functional assessments and the level of engagement is also discussed. To introduce the importance of being prepared, Edward's experience in a mental health setting is recounted.

> *I find my biggest things that working with someone with a cognitive impairment is preparation, making sure I am all prepared and making sure the assessment I am conducting or the work I am doing with those people is relevant, rather than just an assessment. It needs to have some significance and relevance of something that they can grasp on to. I don't really have, that I can say would be a formal tool kit off hand, it would be good though.*

In the example from Edward, he shows there needs to be clear reasoning behind his choice of assessment, which to engage the client. Edward discusses selecting assessments that are relevant to the clients to be able to gain an understanding and facilitate engagement. Edward shows he is selective in the preparation stages to ensure the assessment will have a meaningful outcome. Edward added additional information

by describing the processes and reasoning he uses before he considers the practicalities of setting up an assessment:

> *The things I do to get prepared is certainly use the OT process by screening. So I will screen a referral or screen a person prior to, so I will get all historical events or all historical information available to me, um and I will look to spend some time with the people that work [with] them. So their key worker and get an understanding of what their routine and habits are and certainly get an understanding of who the person is and what their goals are. Then I think I like to assess a person by introducing a concept. If I find that things don't go well from there then I will reassess things. Um, my preparation time usually involves making sure that what I am doing is serving the purpose for the client in terms of what they would like to improve or what their um, family or support staff would like to see improved. I think preparation is important.*

Edward describes his experience of using a systematic approach of the occupational therapy process to prepare to see clients in a community setting, from receiving the referral, to gaining an understanding of the client and his/her goals from the key worker. In Edward's description of his procedural reasoning process, the purpose of getting to know clients and their roles is conveyed in the initial preparation stages. He demonstrates trying to individualize the process, getting background information about clients from multiple sources including the key worker, to ensure the assessment aligns with their lifestyle and goals. In this way he attempts to foster client engagement in the assessments prior to initiating the assessment.

Further to the Edward's systematic approach of gathering information, prior to an assessment Tara also collects background information on the clients' previous level of occupational performance. She seeks to understand the specific occupational issues and what tools or appliances the client uses in the home. As Tara explains:

I needed a little bit more about what she is doing at home, um cause the worries were around cooking her meals, sort of saying what sort of meals is she cooking, using a hob, using a microwave, umm is she on her own? Does she have support? What sort of support does she have available? Umm it turned out she lived with her husband, so that was quite a big piece of information cause he's there all the time that she cooks. Umm and a little bit more about what functional level she was at so I knew what level to pitch my assessment.

Tara has gone further to understanding the social supports available to the client so that she can ensure the assessment is aimed at the right level. Apart from the client's previous level of occupational performance, habits and roles, therapists also need to consider the diagnosis of the client. Ken illustrates this with this example.

But for people with limited insight or somebody who has a condition like an advanced dementia, where no matter how much they explain they are still not going to put all the pieces together because that part of their cognition isn't working as much as it should, um, you have to use other forms of assessment, which is normally a functional assessment. You can watch how they plan, how they sequence things.

The example from Ken highlights a specific diagnosis and the complications of this with the clients limited insight, which can impact on the choice of assessment selected. Ken suggests, with a diagnosis such as advanced dementia that functional assessments are a better tool to utilise so that a person is observed 'doing' versus 'thinking'. The choice of assessment is related to the evidence about procedural memory and being able to perform tasks below the level of conscious awareness, therefore a functional assessment is a more appropriate choice. Adele also supports the notion that when the demands of a formal assessment would be too challenging for the client, completing a functional assessment is an appropriate alternative.

If they [clients] are that bad and they are really worried about it, because some of the tests and questions, [formal assessments] are quite hard because if they are standardized they have to be read in a certain

way. Um, then instead I will look at it in a functional capacity and I won't do the standardized assessment.

The participants point to a number of differences that preparation can make to a client's willingness to engage in an assessment. These include the therapist having a clear understanding of the rationale behind the need for the assessment, selecting assessments that relate to the client's previous occupations, and selecting assessments that are pitched at an appropriate level to the client's diagnosis and functional ability. The next section will discuss the difference preparation makes to the therapist when engaging a client in an assessment.

In addition to the efforts the participants put into selecting the assessment to use, there are other practicalities to consider prior to engaging the client in the assessment. Participants needed to consider the requirements of using a formal or informal assessment, which include the challenges of assessing someone at home compared to the hospital and the best way to set up the environment in either of these places. Tara discusses her experiences of the challenges when using formal assessments in the home environment.

> *Um the MMSE [Mini Mental Status Exam] is probably quite easy because I can do that without having to have all the pack with me. You know if I am out with a client I think I'll just do an MMSE and do one straight off, whereas with the Cognistat I do have to think about it a bit more, get the tool and organize the appointment more specifically um and the AMPS [Assessment of Motor and Process Skills] that is even more time consuming organizing and planning, to make sure they have got all the stuff and I am choosing a level specific for them. I usually start with the MMSE and then the Cognistat and then the AMPS if possible…It is and it is depending on the diagnosis, struck by a stroke and how they can't do a cognitive assessment that they could of done a couple of weeks ago. It is harsh and you have to be more organized going out into the community, to have everything there and setup. Often you would get to the community and can't find a decent space to do it*

[the Cognistat] on or a desk or have to do it sitting on the sofa and it's not really ok to do it on the sofa and do all the tiles and everything.

Tara's example demonstrates that an easy to administer assessment, such as the Mini Mental Status Exam, has minimal equipment required and seems to be the preferred method of assessing a client in a community setting. This is in comparison to the organisation to complete an Assessment of Motor and Process Skills, which requires an agreement with the client to perform two tasks that are selected at an appropriate level or the Cognistat, which requires someone to sit at a table. Tara has acknowledged some challenges of engaging clients in assessments within the community environment. Such as needing to be organised with the appropriate equipment, the difficulties in having a table and chair setup to complete a standardised assessment or not having the available resources to engage the client. If the therapist has taken the required steps in the preparation of the assessment, the right assessment tool can be selected that best meets the needs of the client.

In addition, although therapists may spend the required amount of time planning for the assessment session, the process may not always go to plan. John discussed needing to be confident with the assessments prior to engaging clients in the occupational therapy process or they may not be successful. He gave the following example:

I was going to go back even further, maybe some of the assessments didn't go to plan because we were feeling our way through them and building our own confidence up with the assessment and the assessment wouldn't of gone to plan, because you're nervous trying to say the words right. The client's trying to figure out, that, that interaction… you know so that might be another example of assessment that has not gone according to plan.

This example from John shows that therapists need to be competent in the assessments that they use, as this may impact on the clients' level of engagement during the assessment process. Tracey gave another example of things not going smoothly, despite her awareness that preparation is necessary in an inpatient setting.

> *It, um with all these things when it goes wrong it's cause it's not prepared. You haven't prepared it well, and usually you have not prepared it well cause you have got very short notice from the ward or someone cause they want it, and so you just haven't prepared it well. And you think, I wish, wish I had said no and prepared it…Get that timing right. I will of, I have seen the person before so I know what their routine is on the ward. I look at time of day if I do a second one. Sometimes if people come through again I will do a second one, I write a little time of day, so we do the same time of day. It's not always possible. Um, quiet area, so if they are in a ward of four bedded rooms, then I will, if I can, sometimes you can't take them somewhere else, always pull the curtains across and ask the other patients if it is ok.*

From Tracey's example, assessments can go *'wrong'* when there is a lack of time to prepare prior to completing an assessment, such as an inpatient hospital setting engaging a client in an assessment at the last minute. There needs to be an understanding of the client's routine on the ward in an inpatient setting as well as completing the assessment at an appropriate time of day. The routine on the ward is dependent on the medical rounds, when the client has completed his or her morning routine with the nursing staff and set meal times. Tracey does not want to assess a client who may be drowsy in the morning or not fully alert prior to medication administration. Without this preparation, the client is not being given the best opportunity to engage in an assessment and perform in an assessment at his or her best. This will be discussed further in the next chapter.

Sarah has also experienced difficulties with completing assessments even when changing her working shifts to engage the client in an activity that was relevant to her situation. By changing her working hours, Sarah attempted to prepare the functional assessment at an appropriate time of day, such as, dinnertime, one that would be considered a normal routine. The client lived at the facility where Sarah worked. Even with this preparation of the assessment, when Sarah arrived at work, the client had already completed the required occupation, and was therefore unwilling to engage in the task.

> *I can think of times where we have gone to organise an assessment right down to me changing my shifts to enable it happen and then getting there and then the client has actually already done the task that we were talking about assessing…because they just got impatient and wanted dinner earlier in the day.*

Sarah gives another example of when an assessment does not go to plan.

> *I am trying to think of another one. I can't think off the top of my head of something that was gone drastically wrong. I think I kind of go in with an open mind, and I think in mental health you kind of are used to the unexpected happening, so maybe your tolerance for it is, yeah.*

Sarah highlights the perception that within a mental health setting as a therapist engaging clients within assessments, you need to be flexible in your approach to have successful outcomes, even when the preparation has been thorough.

The information presented shows that therapists need time to be able to prepare assessments. The participants described needing to have clear reasoning to why the assessments are taking place and to select an assessment that is appropriate for the client

and the environment. The participants spent time with their clients to elicit information about the occupations they need to be able to perform, which they experienced as increasing the chances of the client engaging in the assessment process. They also need to be confident in the tools that they are using and it appears therapists within a mental health setting need to be more flexible in their approach, because clients may change on a daily basis. Once therapists are prepared, they move to the next step of initiating the assessment process. This will now be discussed.

Initiating the Assessment Process

This subtheme looks at initiating the assessment process, describing how participants reason about whether clients are medically fit to engage in an assessment process and weigh up the information about clients and their knowledge of formal assessments to ensure a good fit with the client. This encompasses looking at the person's capacity to complete an assessment, for example the impact of delirium or attention levels on the client's ability to engage in an assessment and how that informs the selection of assessments. The participants also consider the client's previous life experience to make judgments about the kinds of skills and abilities they have developed in order select assessment tasks that clients will agree to complete.

The participants discussed a variety of indicators that show whether a client is ready to engage in an assessment. Tracey discussed an example of selecting the right time to complete an assessment with a client who was delirious when initially admitted to hospital.

The doctor had noticed that he had problems with his memory. He does have insight, and he did tell me that he knew he had a problem with his memory. He did tell me that his head was clearing a bit, and so we did a cognitive assessment with him.

Tracey's example shows the client being assessed for readiness to engage in an assessment prior to the actual assessment. The participant used the client's ability to say when he was feeling *'clearer'* as an indicator of when he was ready to engage in the assessment. In this example, the client was also able to indicate that he had a problem with his memory, which in practice is not always observed. Therapists need to be able to judge when a client is medically ready to participate in an assessment prior to initiating the assessment. Tracey goes on to explain the techniques she employed in an inpatient setting to judge if the client was medically ready to engage in an assessment. This also shows how Tracey can notice improvements and rate of change in the client's condition.

So I would just ask him general things like do you know what time it is, can you give me your name again, and do you remember a nurse or someone who's come in. Um, just general things to find out what he was able to give me, what was, where his reality was at…So, every morning I would go in and check the same basic questions with him to what day it is, do you know where you are, all those sorts of things.

Tracey shows using general, almost casual questions of orientation to time and place to assess the client's ability to engage in an assessment. Although being able to judge if the client is medically ready for a cognitive assessment is one component of initiating the assessment process, Ken took into consideration *"their attention levels, um, check the time of day you are doing the assessment is a good time, they are not drowsy"*. Like Tracey, Ken is ensuring the client is capable of engaging in the assessment, so that the client can participate and be given the best opportunity to perform. To make decisions

about engaging a client in an assessment, Ken also gathers information about his or her daily life to inform on the most appropriate type of assessment once the client is ready to engage.

> *I guess as an OT the first part of the OT process, the whole diagnosis part it's more like it's I need to take into account the person's everyday life, everyday routine, it's a very holistic way of thinking and assessing as well.*

To enable a holistic approach, when occupational therapists first meet with a client an initial assessment is usually completed, which takes information about the client's previous occupational performance when in a hospital setting or how they are currently performing at home or in the community. Ken takes one step further into considering the previous level of education the client has had prior to the assessment as shown from the example below.

> *I said at the beginning, holistically you have to think about where is this person coming from, or what was their level of education previously. Um, do they know what we are going to do with the information?*

Ken highlights two considerations relating to his knowledge about assessments. The first is what the therapist knows about the person and the second is; whether the client is aware of what will happen to the information. If assessments are not selected appropriately to the client's previous level of education, the client may decline engaging in the assessment, because it may be perceived too demanding for him or her to participate in. Additionally, if clients do not know what will happen with the results of the assessment, they may not willingly engage, as they do not know what the outcome of the assessment will inform in relation to the future.

Similar to Ken, Adele gives her experiences of the differences when initiating a cognitive assessment or a functional screen. Adele is responding to what she knows about the client's life history, and also the client's personal attributes and her sense of the client's previous education.

> *It depends on the clients. Some people really love, you know, being challenged they want to know how well they have done; you know they are quite competitive in that way. Whereas others, it's mainly the low level clients, um, lower intelligence clients, would rather do a lot more practical functional stuff. So then I would try and pick the practical functional elements of the screens and just pick out those types of bits.*

Adele's example shows her experiences of some clients enjoying being challenged by formal assessments and other clients preferring a functional approach. In her effort to ensure clients will engage in the process, Adele suggests that she does not necessarily administer formal assessments in their entirety. That is, her concern to gather some data in ways the client will encompass appears to override concerns about the validity of the assessment result or the integrity of the assessment.

So far, the client's ability to engage in an assessment has been discussed in relation to whether a formal or functional assessment is selected. In order to initiate the assessment at the right level for the client, participants reported asking about clients' current occupations. Some participants collected this information in the preparation stage, as previously discussed. Here, the purpose differs in that the participants were using knowledge of the client's current occupations and occupational history to decide whether to use a standardized or a non-standardized assessment. For instance, Sarah discussed using her knowledge of the client's previous roles to initiate a discussion about assessment purposes. Sarah's account reveals how she has interpreted

information about the client's roles and responsibilities to get a sense of her life roles and which occupations are important to assess. These are the same concerns that Ken discussed previously; with getting an understanding of the life the person leads prior to determining the assessment priorities.

> *We talk about wanting to evaluate her skills um, in order to, pretty much you know to support her to continue in what she is already doing. I am of the opinion with this client in particular that so much of her identity is in, sort of those occupations of traditional family values like the cooking and house keeping, she was, she is still very much a wife who attends to her occupations in her own home.*

Ken uses knowledge of what has been important to the client over her adult life to determine in which occupations she will continue to want to engage. That knowledge reveals the tasks and abilities he needs to prioritise in his assessment. Sarah continued, showing how that information was put into practice to engage the client in further occupational therapy assessments based on the client's known capabilities.

> *I guess it's a way in which we draw on her to engage in a group situation. So we will draw on her expertise really explicitly, saying "ok" so and "so what do you think? What did you do when you were younger to make your cakes rise or something?" So drawing on that just in conversation and with others. I think it's that whole thing of wanting to be needed and wanted as well you know…. we were doing some baking once, and um there was her and couple of other clients in the kitchen so had a little group going on. And this client she didn't do anything with the cooking, but demonstrated to others how to do it. So she took on a teaching role, which was something that blew us all away because we are used to her um, not doing that at all.*

Sarah explicitly shows the information gathered on the client's previous roles can be used to formulate and initiate an assessment based around these specific occupations and skills. She demonstrates that by using an informal assessment process she has allowed surprising capabilities of the client to emerge that may not have come to light in

formal assessment environment. Using this method the client has engaged in the group setting with showing other clients how to complete the task.

Similarly, Ken discussed two of his clients' previous occupations and what decisions were made in initiating engaging one of the clients in an assessment. Ken's example compliments the role perspective previously discussed by Sarah, because he shows attempting to take into consideration that the clients were *'practical'* people when initiating the assessment. Despite considering the client's life history, the client still declined to continue with the assessment. This may have been due to the realization that he may be *'found out'* with the difficulties in managing money and daily tasks being true. Instead of discussing this with the therapist, the client has declined to continue to engage in the assessment.

> *Both of them actually, two gentleman, and they were very practical; I think one was a fitter and turner and the other had worked on ships in the war in World War 2. They were very um, skilled with their hands, and the types of assessments that we have don't normally have those components to them. There is a little bit but to them and their normal life and the way they were bought up, they didn't have to think through or problem solve them much. Things were given to them and they would just do it. And the type of assessment I used, actually looked a bit more problem, part for both of them, they were living alone and having trouble with managing their money and making sure they eat on time and doing their shopping. Those kind of daily tasks, and one got about a quarter the way through and said "Look this is enough, I don't think this is going to help me at all, I want to go back to my room", and I said "Look, can we look at doing a bit of it tomorrow then?", and he said "No I have had enough."*

Even though Ken attempted to have an understanding of the client's life history and previous occupations prior to initiating in the assessment, he indicated he did not have an occupational therapy assessment available that matched the skills of the person to the components of the assessment. The client has started to engage in the assessment and it

maybe due to lack of understanding to why the assessment is being completed and how it relates to everyday life roles that the client withdrew from the assessment and declined to continue the assessment at another time. This example shows therapists need to finely match assessments when initiating an assessment with the clients who have a cognitive impairment to successfully engage in the assessment process.

Similar to Ken, Adele described her experience of responding to the client being a 'practical' type of person and using components of a standardized assessment and functional task.

> *I kind of used the practical elements you know like the functional screens, like the following instructions of the COTNAB, that's quite, screws, plates, bolts those sorts of things and the elements of the COTNAB as well. Then will do like a functional task outside and then relating to money I will try and you know use function in relations to, wrangling in a couple of questions maybe to give me a better idea.*

There are challenges when initiating functional assessments from components of standardized assessments. The participant has described being unable to complete the standardized assessment in the standard manner to maintain the assessments reliability and validity. Choosing assessments that are relevant to the client appears to increase the likelihood of clients with cognitive impairment engaging compared to bringing information from multiple assessments together to get a true picture. Information was not collected on how therapists documented their findings based on completing only a few sections of standardized assessments and completing functional tasks.

Aside from deciding between initiating informal and formal assessments, John has experienced difficulties when introducing a new activity on which clients will be assessed on. Engaging the client in a formal, unfamiliar assessment gives the client a sense that they cannot cope.

> *I think so, um, sometimes when you actually produce the leather lacing kit to clients and um, stitching is not one of their, you know something that they have never done and they can be intimidated by this and I have seen this before, um and they will actually say to me, "Oh I've never done this, you know I've never stitched in my life how can I cope?" And in those situations Allen's Cognitive Levels you probably know that. Um, there are other activities you can do. Not just the leather lacing which transfer, the um, which also give you, so if someone is, feels that it is unfair that we are making them do something that they have never done in their life, and we do explain that everyone should be able to do this, it's quite you know, but, if they are resistant, you just use another um, form of the assessment which, which they feel better about. But that's if there is a lot of resistance. Because people become resigned to um, I feel people come resigned to the assessment and you won't get a, you know a proper reflection on how they are. So I think it is always good to um, have the client feel comfortable with the assessment.*

John has responded to the client's responses to the assessment that is intended to assess cognition. John employed techniques of trying to reassure the client by saying that everyone should be able to do the assessment. This may heighten the clients' anxiety about completing assessments if they are unfamiliar with the task and already feeling overwhelmed. The client may continue to decline to engage in the assessment and the therapist to think of more suitable assessment tasks. John went on further to discussing the importance of making sure the client is familiar and comfortable with the assessment tools used prior to initiating the assessment. John indicates that if a client feels *'resigned'* to complete an assessment, this will not capture the client's true level of cognitive functioning.

Edward recounted his experiences with a client that also illustrates the need for clients with cognitive impairment to be familiar with the objects involved in the assessment prior to initiation.

> *Um, what did we do? Um, I showed him several things that we were going to use, showed him the props, so he was familiar with the key, the pen and the paper. Um, so the idea of that was to make it fun, he works better when things are enjoyable, and it's usually more so that it creates boundaries to what we do so, asking the questions exactly how they should be asked, so, very concrete.*

Edward uses his understanding that the client needs structure and tasks that are enjoyable when initiating an assessment. Formal assessments can create this structure, which Edward has found successful with this client group.

An additional factor that therapists working in mental health settings need to take into consideration when initiating assessments is the risks involved with someone who has been classified as a 'self harmer' and what type of assessment would best suit this person. The therapist needs to be aware of the contra-indications of assessments. This example from John explains.

> *Yep, we are particularly looking at risk. So if I have someone who's a big self-harmer or who knives, we will avoid the kitchen, if um, just to flip it around it's also looking at where existing skill deficits have been identified.*

The information presented shows there many factors that therapists take into consideration when engaging a client with cognitive impairment in an assessment. Therapists are concerned with initiating an assessment to give the client an opportunity to perform at their best, and not ask for abilities the client never would have had and are

irrelevant to their lives and skill set. The client's diagnosis and being comfortable with the assessment are also perceived to impact being able to initiate the assessment process. The participants discussed the importance of gaining the client's current occupations and occupational history and matching this to the right type of assessment. The client needs to understand the rationale for assessment and what the outcome of the assessment will mean for the client's future to successfully give informed consent prior to the assessment. The participant's reports gave a sense that they experienced an increased difficulty engaging clients in assessments that were not specific to occupational therapy, and a greater success in using occupation based assessments. The involvement of a third party during the assessment and how that impacts the client's level of engagement will now be discussed.

Third Party Involvement within the Assessment

Therapists often need to complete assessments with clients with family or other staff members present, within the home or hospital setting. Some of the participants indicated having experienced difficulties with engaging clients due to the family interrupting assessments, giving verbal and non-verbal cues or minimising the cognitive changes of the client. The participants discussed family members and clients finding the assessments stressful and an emotional time. Each of these difficulties experienced by the participants will be presented.

Family members being present at the assessment can cause barriers to engaging the client in an assessment and prevent therapists from getting a true picture of the client's level of functioning. Tara discussed her experience of the differences if a husband does

or does not attend the visit while she was completing a cognitive assessment with his wife.

> *The husband was not there for the assessment, he was working, which was quite good because my understanding with the husband was that he kept making excuses for her difficulty, and one of the reasons they wanted the assessment was to start letting the husband know that she couldn't be left to cook things without him being here to monitor her. So it was quite good because my outcome wasn't affected by his inter, not interference as such by his involvement I guess, but um the other side of him not being there was he could not see the risks that were coming out of it, she did not turn the hob off after she carried out the assessment, she couldn't find things in her own kitchen, um so it would have been quite good for him to see, does not appreciate how much he prompts her without realising, so there are pros and cons with him not being there and I was um not actually able to catch up with him again because of the distance, so he had to, I had to formulate a report that he would be able to read and make it appropriate for a, husband to read about his wife and showing what impairment she had and key worker had to explain the impairment, what I had found.*

Tara has identified some of the benefits of a family member being present during the assessment. These include the family member being able to observe the difficulties the client is experiencing with certain occupations and how much support is required, rather than relying on outcomes the therapist has drawn from the visit. At the same time Tara acknowledges the difficulties the family member may face and behaviours they exhibit when being present during an assessment. Examples of this include minimising the impact of the cognitive decline or being unaware of the decline and its true impact on the client's ability to manage everyday occupations. Ignoring or being unaware of these difficulties can put the client at risk when completing certain occupations, such as cooking. Tara then gave her experience of the family being present for the assessment and the emotional response it can elicit from the family.

> *I think the thing with having a family member there is it's very difficult for them, from a personal point of view, cause you can see them getting upset because their loved one can't carry out the task they should be*

able to do. Secondly they find it hard not to say something or help their loved one, so you have to be really clear with them that they have to stay out of the picture, that they can be there to observe. So it is quite hard having a loved one being there but having said that, they really see that for themselves. You don't have to write a report or try and explain to them as they can see the evidence for themselves, so it is beneficial to have them there from that side of things.

The other benefit Tara mentions from her point of view of the family member being present is that she does not have to write a report that outlines the specific difficulties that the family needs to be aware of and understand, because they have observed the difficulties themselves.

Therapists need to set clear boundaries with the family who are present to not interrupt or change the results of the assessment. Edward's experiences with the family being present illustrate this. The family members are shown to answer the questions for the client and the challenges when there is emotion involved with the assessment, as Edward explains.

I have had family members that will um, answer the questions for or attempt to magnify the answer, as if to say, s/he is actually not that bad or, a lot of them will minimise behaviours or responses to things, so there is a lot of minimisation and magnification that family often do as a way of making them feel better about themselves or trying to encourage that person to feel better although it can distract from the actual assessment itself. So I think there is a lot of magnification and minimisation involved as well as there is whole emotional low of these assessments and the emotions get involved, and the emotions then feed on to the person doing the assessments. So yes sometimes having family can be a good thing and sometimes not.

Edward has shown the role the family members take in encouraging/assisting the client through the assessment. The client and family can hinder the results of the assessment, making them inaccurate by providing this assistance. The family may interrupt the

assessment to encourage the client or themselves due to the level of emotion that can be experienced. Until the assessment is completed the family may not realise or acknowledge the full impact of the cognitive decline on the client's performance in everyday activities, which can be a very upsetting time.

Further difficulties of the family being present during the assessment are the effect it has on the client's ability to complete the assessment. Having someone else in the room during the assessment can reduce the amount of attention and concentration while engaging in the assessment, thus impacting on the client's level of engagement. In contrast, having a family member present may relax the client and make it easier to engage in the assessment. This example from Tara illustrates that impact of the family member being present during the assessment.

> *I think the difficulty with the family member is there, is that they are also distracted, and so yeah they are probably a little more relaxed and they are not as focused on the assessment that you are trying to do, so it, it can take away their concentration or their attention or their involvement. So it can sometimes be negative and in that respect.*

So far the emotional impact of having a third party present during the assessment has been discussed. The discussion now moves to the decision of having a third party present and what this means to engage the client in the assessment. The participants are shown to have a difference in opinion on whether the family should or should not be present during the assessment. Tracey discussed her experience of not encouraging the family to present for the assessment.

> *Usually what happens, I give them a choice, but I kind of encourage them not to be there, unless they can sit back and out of the way, because sometimes [the client] will look for answers from the family and the family sometimes want to will them on and might just give them a verbal*

clue or just some clues you know. You have got to be really hard about clues, because I am a really handsy person, don't give them any clues.

Tracey reports she gives the family and client a *"choice"* on whether to be present during the assessment, however she does not encourage the family to attend due to the family disrupting the assessment and causing the results to be invalid. Family members can do this by giving verbal and non-verbal clues. Adele has had similar experiences as described below.

Things the family do to show that they are assisting the client through the assessment or they non verbally lift their eyebrows to prompt [the client] to the right answer. Once again, it's saying to the family "You can sit in on the assessment as long as no one says anything. This is their chance to show you what's happening with their cognition", and sometimes you say that and the family still go ahead. I have had people come back to me and say, 'Well that was a really hard one, I couldn't even do that', and that's a very common thing that comes back. Being a standardized assessment you have to follow this pathway, it is up to the you as the therapist before you even do the assessment to check the previous level of education.

Adele confirms the same issues with the family assisting the client verbally and non-verbally and goes on to further acknowledge the need to ensure that the assessment is pitched at the right level or the family may question the level of difficulty at the completion of the assessment. Nonetheless, there is a sense that the participants feel a need to stay in control of the assessment process and not let the family take over. Although Tracey and Adele prefer not to have the family present to complete assessments because it affects how the client engages in the process, John reports he will not complete a standardized assessment if the family is present.

I won't do standardized assessments with a family member involved. However, I will ask the client to make a cup a tea and tell families I want to see how they manage this…there might be a little bit of awareness going on because there are family members there, but if there are family members present it's generally in a home situation and in my experience

trying to do, undertake an assessments with family present, it just doesn't work sometimes because they will answer for them, they will jump in, they will shake their heads.

John's example shows his experiences of family being present during the assessment has led him to the decision that the family cannot be present during any standardized assessment. His rationale is the same as previously mentioned by Adele, Tracey, Edward and Tara. However, John highlights with family members being there, it may create an environment of awareness of the potential difficulties due to the cognitive decline. John shows he will have more flexibility and have the family there in a non-standardized assessment or functional assessments.

In contrast, Sydney and Sarah were the only participants who agreed for family to be present during an assessment. Sydney *'strongly encouraged'* the family to be present during the assessment. Sydney explains.

I strongly encourage them to be present. Because it is the most marvellous method of them learning what is actually the problem and not only that, it gives me excellent collaborative evidence of what's actually happening. Cause when they see their family member not performing as they expected them to um, then, then that gives me ideas about what's different, um and when the say, when they see them performing in a certain test and you help them make sense of that like for example if it is a memory problem and you come to the conclusion that that the problem the person has is that they are unable to pay attention long enough and they are not up loading information um, and that that's actually the primary concern…And come to a family meeting and you can say do you remember you did the test and this, this, this happened and everyone is sitting there nodding their heads saying 'Yes we remember', So they all have ownership and I think that is important because particularly we have a very large Pacific, Indian, Maori and Asian population. It is huge and they are very much focused as family on how their family member is doing. So if you have them involved in the process it's much easier to get the engagement, discharge planning and the supports in.

Sydney demonstrates how she uses the family being present for the assessment as a method of 'learning' for the family and the therapist together. Sydney shows that as the therapist she can use this time to assess previous and current level of functioning. Family can observe the assessment for themselves and have the therapist explain what is happening and what changes they might see during and after the assessment. Another benefit that Sydney uses is sharing the information within family meetings and giving the family *'ownership'*. By using this approach, she acknowledges the cultural importance of family and knowing the principles of the Treaty of Waitangi. This approach is beneficial when working with clients of different cultures when the focus is on the family as a whole being engaged in the occupational therapy assessment.

Further to the family members being involved, there maybe situations where other staff members will need to be involved during an assessment.

> *When other staff are involved they [clients] feel slightly more intimidated and that breaks, I guess that inhibits their own thinking because they are very easily distracted, distractible and he always performs when other people are around. It's like I said before, and it just comes down to his cognitive ability. Yeah that he feels pressured.*

Edward shows there are three factors to consider if there is another staff member present. The first is the client not maintaining attention to the task, the second is being intimidated by other staff members being present and lastly, the idea of needing to perform at his or her best in front of others. Edward now discusses the techniques he uses to ensure the client is able to engage in the occupational therapy assessment.

> *Um, what I would usually do would be to minimise the amount of distractions. Um, in the environment as well as with those, the people that are around him. So I would ensure that those that are present during the assessment he felt comfortable with, otherwise it would*

certainly change the outcome. Yep, so environment and people are really important. So briefing them before with what we do in the assessment I think that is really important as well as briefing others about what you are intending to do.

Edward acknowledges the impact other people may have on the client's performance during the assessment. To try and minimise these distractions he ensures the client is comfortable with the assessment and does this to ensure the client is given the best opportunity to participate in the assessment and obtain the best outcome. Edward does this by preparing the client and third party for what will happen during the assessment and Edward has found this successful. Further insights come from Candice who discussed her strategies for managing if the family are visiting the client in an inpatient setting when she is wanting to complete a cognitive assessment.

Um, I don't normally ask people at the time that family are present. Mainly because they are with their family and I don't think that sending family away to sit somewhere else is really going to help them concentrate in [they would be] trying to work quicker probably, um. So if the family are there I kind of think that if I send the person's family away that they will be too rushed thinking about their obligation to seeing their family or visitors, so I generally try and get to them in the morning.

This example from Candice shows her concern with the client's ability to engage in an assessment when the family is present. Unlike John who will not do assessments when the family is present, Candice selects a time to engage the client when the family are not present and the ward is not open for visitors. Candice discussed the potential risk of having an altered level of concentration, and understanding from the client's perspective of wanting to spend time with the family when they are visiting. The outcome of the assessment may be affected if the client is unable to attend for the duration of the assessment.

Presenting a different perspective, however, Edward had mentioned earlier that clients might perform better in the presence of staff. Sarah discussed her experience, also within a mental health setting, of a client who presents better when the family members are present.

> *Um, with the first example I gave of the client, her general presentation is better with family around on the whole…I guess her mood is a lot better in general; she is a lot more trusting because there is a third person there for her. Um, and she always wants to, almost, not be good, but she wants to act in a way that is appropriate for the rest of her family to see…almost like putting on maybe a bit of a show, or and there is a element for this lady of she doesn't want to show that she is deteriorating as well. So she will try really hard to lift herself up, um because her family members are there.*

The client in Sarah's excerpt shows she wants to perform at her best in front of her family and behave appropriately for her family to observe. The client attempts to hide her cognitive decline and prevent the family from seeing the deterioration in cognitive ability.

In summary, this theme shows that the participants had different perspectives on the involvement of a third party being present during the assessment phase. Some participants found that having the family there can be distracting, lowering concentration levels and affecting the outcome of the assessment. Changes have been observed with the clients' willingness to engage in the assessment process with other people present. Other participants worked on the principles that the family being involved with the care of the client and being able to observe the assessment first hand and discuss the results is beneficial. Additionally, there were some suggestions that

clients in the presence of family tried to perform at their best, hiding the potential change in functioning and cognitive decline from the family.

Summary: Managing a Complex Process

In this chapter the theme of managing a complex process was presented. The first step to engaging the client in the process is to obtain informed consent. The participants showed an awareness of the need to obtain informed consent and used a variety of strategies to do this. The role of occupational therapy and the purpose of the assessment were presented in different ways, with simple and easy to understand language appearing to be more successful. Once consent was obtained, the participants discussed the ways they prepared prior to initiating the assessment process. The participants were guided by their central concern of identifying occupations that are relevant to the client's current situation and life roles, although that was not always possible given the constraints of the formal assessments available to them. When preparation was complete the participants moved into initiating the assessment with the client. The participants considered if the client was medically ready to participate in an assessment, the previous level of education and if the client enjoyed being challenged. Having a third party present during an assessment was shown to at times hinder the assessment process by reducing concentration levels and attention to the assessment. There was a difference of opinion about whether the family was welcomed during an assessment because of the impact this had on the client performance. Once the process to engage the client in an assessment is completed, the findings turn to the ways therapists use the relationship with the client to recruit cooperation, which is discussed in the next chapter.

Chapter Five: Recruiting Cooperation

Introduction

In the first findings chapter, it was revealed that engaging adult clients with cognitive impairments in assessment processes involved obtaining informed consent, being prepared for the assessment and the different ways that the participants initiated the assessment process. The presence of a third party also had an impact on the clients' ability to engage in assessments. In this chapter called Recruiting Cooperation, the discussion turns to the ways occupational therapists draw on their relationship with clients to recruit their cooperation with assessment processes. The findings in this study uncover that occupational therapists use a variety of techniques to develop the client-therapist relationship, which plays an important role in engaging clients with cognitive impairments in assessments. There are several themes presented in this chapter including 'building rapport: recruiting the client', 'offering enticing assessments', 'understanding the person' and 'the role of therapeutic communication' in engaging the client in an assessment.

Building Rapport: Recruiting the Client

The first subtheme that emerged from the data was the need to develop rapport as a first step to engage adult clients with a cognitive impairment in any assessment process. Rapport can be described as the communication and interactions between the client and the therapist and is a means by which the client achieves a positive outcome in therapy

(Trombly, 1995). The participants discussed a variety of strategies to build rapport and the therapeutic relationship in order to recruit the client's cooperation to engage in the assessment. The strategies the participants used included being solution focused, the use of pleasurable moments and the occupational therapist's personal attributes. Each of these will now be presented.

The first example of building rapport comes from Candice. Candice experienced the client and family recruiting her to being "onside" with them, to assist with achieving a successful outcome when being faced with being in hospital. This example was unique, no other participants discussed a similar scenario. Candice initially presented the role of the occupational therapist in the client's favour to achieve the client's goal of returning home. Candice discussed her experience of feeling that *'people adopt you into the family'*. She described how she can be seen as the person who has the power in the relationship to make decisions about the client's ability to return home, therefore the client needs to collaborate with the therapist to ensure there is a positive outcome. Candice shows her experience of presenting information as being solution focused with a client being in hospital and their ability to return home.

> *I don't know, I just kind of get a feeling that most people adopt you into the family. I don't know if that makes sense, do you know what I mean? They just want your help, they want to go home, they are very obliging they you know, they are open minded, they are willing to listen. If you are pleasant to them they will be pleasant back. And yeah, to a large extent even to any culture from that sense because you know they are very pleased to hear from you cause after you have explained your role they know that you are the link between them and home and you know you have talked about what equipment they might need and you know they are very excited that there is a solution really. So I think probably I guess presenting the idea of the solution to their current situation is probably a good rapport builder.*

In Candice's experience, presenting a favourable solution to the client's current situation can enhance engagement in the occupational therapy assessment processes. When therapists are seen as the link between being in hospital and being discharged home, clients have a reason to engage with the therapist, and willingly respond to approaches used by the therapist. Candice's positive approach on being solution focused when interacting with clients and their families seemingly enhances rapport, paving the way to the assessment process within the client-therapist relationship. Candice further discussed her role in working in collaboration with the client while still using a solution focused approach.

> *Yeah like you are not telling them what to do, you are asking them what you need to do for them. That's the way that I approach it, you know. "Can you tell me what you think is going to be a problem at home", "are you worried about anything at home" rather than "well I know your type, I am just going to give you this, this and this". (laugh) That's not going to work.*

Candice demonstrates using phrases that recruit the client into the relationship by understanding what the client needs most from the therapist to return home. This client-centred approach creates a sense of a shared understanding of what is important to the client to return home and an equal relationship by sharing the power with the client, by asking them what the perceived challenges are at home. Candice explained a direct approach of telling clients what they need to go home is not going to build rapport or create an environment to foster engagement in the assessment.

The second strategy to build rapport that emerged from the data was engaging clients in pleasurable activities, such as leisure activities. Sarah has learnt that to engage a client in occupational therapy you need to discover what interests the client. Sarah discussed

her experience of encouraging the key worker to take the client out to *'do something nice'* together, can start to build the relationship. Sarah described:

> *I think the trick is to find that lever, you know. Like for one guy he wanted to, there was a support worker and he could not engage with his clients, so we decided you know take him to the movies, take some money and do something nice together and see how that, you know even though I wasn't directly involved in observing it, I was able to elicit from the client later and the support worker later what happened you know. So from there it is getting those nice things in life you know.*

Sarah was able to obtain feedback from the client and key worker on how successful this strategy was. Occupational therapists are unlikely to have time to take the client to the movies in order to encourage them to engage in an assessment. However, the principles of sharing pleasurable moments and opportunities for listening that the therapist has actively constructed remain true. Sarah felt that time and listening is an important step in developing rapport and recruiting the client to engage in an assessment. Sarah gave this example to reiterate the role of listening in building rapport with the client to gain a deeper understanding and in doing so strengthening the relationship. Sarah explains:

> *Just spending time with her, just rebuilding and listening. I think the biggest thing with this client in particular was listening. Um, because of the complex delusional structure, just listening to it, um, you know, very traumatic…yes listening is the key and I think the other key thing to recognise for them all is that they have had some form of trauma. Um, coming into mental health services, be it being you know, the first period of unwellness when they are taken away by the police into the inpatient unit, through to being in a place where you have all these limits put upon you.*

Sarah's experience when working in a mental health setting shows there are other considerations when building rapport with clients. Sarah believes it is important to understand how the client came to be in mental health services, because often there is

some form of trauma involved, therefore empathetic listening plays a key role in developing rapport with all clients, including those with cognitive impairment. By using listening skills, Sarah is building the relationship to understand the client to then recruit him or her to engage in the assessments required.

Further to listening and sharing pleasurable moments as discussed by Sarah, the occupational therapist's personal attributes can play a role in developing the relationship. This was the last strategy that emerged from the data in relation to Building Rapport: Recruiting the Client to engage in assessments. Tracey discussed her experience of developing rapport with the client and the links she makes to her communication style and skills.

> *To be honest I think I am one of those lucky people that has that ability to build a rapport with someone. So my people skills I believe are good, probably because I am dyslexic so I am used to being verbal rather than writing everything down, so I think it is just having that open personality.*

Here, Tracey described the benefits of having an open personality. She attributes her skill in building relationships with clients with cognitive impairments to being a verbal person rather than written due to her dyslexia, and believes that assists her ability to recruit the client to engage in a therapeutic process, which will include the assessment. Similarly, Candice describes one of her personal attributes as being cheerful and explains how she uses this as a way to develop rapport. She also discusses the balance she strikes between being formal and informal in her approach, when first meeting with clients.

> *I think it is about being cheerful, um, but actually I would say in the first instance it's about just being more formal until you have sort of introduced yourself. Because I always find the way that they react to me*

in that first sentence back to me when I say who I am tell me whether I need to stay at that formal level or whether I can be more of a chat and a discussion.

Candice starts an occupational therapy session with using a formal approach when introducing herself and the occupational therapy role. She is then able to judge from the response of the client, whether this needs to continue or whether she can move to a more informal level and have a friendly discussion. This method is based on her ability as the therapist to interpret the situation and to discern how she needs to continue.

Developing rapport with clients is one of the key components to developing the client-therapist relationship, one of which therapists are mindful when they encounter clients who need to be assessed. The participants appear to have their own ways to successfully development the relationship and build rapport, whether this is through using pleasurable moments, being able to actively listen to the client or presenting information in a solution focused manner to get an understanding of the client and recruit engagement in the assessment process. There was a sense from the data that the participants used these strategies to build rapport with client with and without cognitive impairments. Offering Enticing Occupation Based Assessments will now be discussed in relation to engaging the client in assessments.

Offering Enticing Occupation Based Assessments

The next subtheme that emerged from the data was how the participants' choice of assessments was influenced by their effects to entice clients to engage in the assessment process. The participants persuaded clients to engage in assessments by ensuring the

assessment process would be rewarding. This subtheme differs from Initiating the Assessment Process, which was discussed in chapter four and which focused on decision making in relation to the clients' capacity to engage in an assessment and matching the assessment tasks with the kinds of skills clients had established over their lifetime. Offering enticing occupation based assessments was achieved by selecting assessments that related to more global concerns such as the clients' meaningful activities, roles and cultures. Engagement and choice was also influenced by the need to do formal or informal assessments.

The first important consideration that emerged from the data is to choose an assessment that is culturally and personally appropriate to the client. Sarah explained needing to consider the roles and culture of the client before selecting an occupation that might be used for assessment purposes. This example was given by Sarah, *"I also think the culture as well; we have a few Maori clients who really see food as an integral part of their lives and the customs around food as well"*. The participant is seen to understand the value of food within the client's life, as a basis for drawing the client into the assessment, and in doing this providing occupational therapy intervention that is meaningful to the client. By choosing occupations that are meaningful to clients with cognitive impairment increases the likelihood they will engage in the assessment because the client can see the reward at the end of the assessment.

Sarah further reinforces the ability to identify what was meaningful and familiar to the client to have the right occupation-assessment match as a successful strategy. This

enabled Sarah to get a better sense of what the client was able to do functionally, because he engaged willingly in a familiar and meaningful task.

> *Um, there was one guy, the second guy I was talking about that was not very engaging that did not want to go on the supermarket trip. He stated to me he had a long history of being a chef and a real variety of skills and then he had also no insight into his illness and somewhat delusional as well. We started cooking and he was amazing. Like he looked like he knew like he was a chef you know and he was cooking steak, but he was using herbs and things that I had never heard of. He was you know, more than appropriate in what he was cooking, with the sequencing of what he was doing, he was, I was really surprised how he could communicate with me while also cook and follow such a complex meal without instruction. Yeah I was like wow, this doesn't look like you would know how to do this looking on paper your presentation.*

Sarah showed her initial doubts about the client engaging in the assessment, because he had not responded well to assessments previously and was reluctant to start to engage in the assessment process. The task selected by the participant was meaningful to the client in that it related to a valued role. The assessment yielded a surprising outcome for Sarah, because it showed the unknown abilities and strengths of the client to emerge as he was engaged and on automatic pilot. In offering an occupation-based assessment to which she hoped the client would respond positively, Sarah gave him an opportunity to demonstrate what he was capable of doing. In working with clients with cognitive impairment, there was a sense that, if therapists could get clients fully engaged in the assessment by basing the assessment on something familiar and meaningful, they could collect the best information to get a real picture of the client's presentation. Sarah shows once again that a client who is engaged in familiar functional tasks associated with valued roles may reveal skill levels that surprise the therapist. This has shown to be unique to functional tasks, because none of the participants described revealing surprising skill levels in formal assessments.

John also has experienced choosing an occupation that was attractive to the client, which also offered a pleasurable reward for the client and the opportunity to go out in the community. John explains:

> *Initially I needed to see what she was like in the community. So I said to her "listen I would like to see what you can do um, thought we would just go for a coffee, and you know go from there"…she freely engaged, because we were actually going out for coffee. Um, actually I did tell her I wanted to see how she was crossing the road and things like that so she got an indication and she was fine with that. Um, we went out, the road safety assessment, and um, see how she behaves in public and buying a coffee and things like that. But she, I don't think, part of me thinks she wasn't fully aware that there was an assessment going on although she had been told, she was just, it was just it was just, a normal thing for her.*

John's example described how he was successful in engaging the client in an enjoyable task, however he questions whether the client was fully aware that she was being assessed while engaging in this occupation. John explained that her lack of awareness to being assessed might have been because it was a *'normal thing for her'*. However, the client may not have fully appreciated she was going to be observed and assessed while going out for coffee. This raises an important point; that clients need to be fully informed about what assessments therapists are engaging the client in, particularly when enticed to engage in a meaningful and enjoyable occupation.

A further example of an assessment that can be considered attractive by some clients is driving. Driving is an important role in people's lives because it is a form of independence. Adele described her experience of engaging clients in an *'off road driving screen'*.

> *But with those type of clients, they always want to get back to driving and in order for driving they have got to go through the off road driving screen, so that incorporates everything. If in doubt I will just leave it, I will do functional stuff until I do the driving screen and then that will just give me an idea and nobody has refused to do that. Or otherwise they will have to pay $400 with DAS [Driving Assessment Service] or OTRS [Organization of Therapy and Rehabilitation Services]. Yep.*

Adele demonstrates how she has used functional tasks with clients who have been reluctant to engage in other assessments until completing the driving screen. From Adele's experience she has not had anyone decline to engage in this assessment, because the result of declining means the client needs to access another service to complete a driving assessment at an additional cost.

A participant discussed her experience of using the occupation of cooking as being more successful with clients to engage them in within their clinical setting than others. The setting was a residential mental health setting, which has the focus of rehabilitating clients to return home within 12 months of admission. This example shows how the therapist used her tacit knowledge. As the participant explained:

> *I think cooking is the most engaging occupation, cause they can eat at the end, um because they are on such a limited budget um and I think that a lot of the skills for cooking are transferrable out. Trying to engage someone, oh look lets do an observational assessment of you cleaning your bathroom you are not going to get as much bye in…even throughout the whole service food is a big, big push, yeah. I work with people who get $50 a week for groceries so having, having something nice and an opportunity like that, is I think quite special or quite unique in terms of how the work plays out.*

The participant shows what she has learnt through experience within the service. Cooking is an occupation that can be assessed and the skills transferred to other areas of people's lives. The participant discussed the enticing benefit for the client to engage in

cooking food that is outside the normal routines of the setting and budgetary constraints. By the client engaging in this assessment, there is a known reward at the completion of the assessment. This knowledge has been gained through clinical experience and it has shown to be successful in other treatment sessions. The participant further goes on to explain needing to justify their reasoning behind a cooking assessment to their manager.

> *I had an interesting situation when I was setting up to do a cooking assessment with a client my boss sort of said why are you thinking about this much I just need to know if he can cook or not. And my boss is a social worker and I said actually for my assessment an OT it's not quite that simple. You know I am breaking it down into the different areas because sure I can tell you if this client can cook or not but that's not going to do any good in terms of skill development and what you actually want this assessment for, you know. Um, some people I think, I know if you can assess that you can cook, clean and take their medication you know there is your gold star and you are out in the community, um but it is just not that simple.*

The participant uses a task analysis approach by assessing the occupation of cooking into different motor and process areas and trying to identify the client's strengths and limitations. The therapist is able to then use the results of the assessment to plan for reintegration into the community. Occupational therapists are often required to justify what they do to their managers and Sarah shows taking a holistic approach and wanting to develop skills with the client, avoiding the perceived expectations of when someone is ready to be discharged to the community.

Therapists have had to be adaptable with the client and be able to make quick decisions about whether to engage clients in an assessment. This example is from a participant who had to work hard to entice the client to engage, when the strategy of offering food proved insufficient. Sarah described changing the planned assessment when the client

had pre-empted part of the assessment task and without that component, the participant would be unable to gather all relevant information. As Sarah explains:

> *I did really specific cooking assessment with one guy who was just like, why do I need a cooking assessment you know, and even to the point of, I said to him right, let's just consider this a free feed on the service, humour us, tell us what you want to cook and then we will go to the supermarket and then we got to the point of going to the supermarket and he said, I don't need to go to the supermarket I have got all the ingredients, which just about knocked out the first layer of my assessment. So I'm like look, who cares, we might just go to the supermarket anyway so we can get what you think you might need for the coming week you know here is the budget let's roll.*

Sarah has described a situation that called forth a further approach to elicit the client's cooperation by presenting the information so it will be of benefit to the client to engage in the assessment. Sarah has drawn on the client's limited financial means while with the service to engage the client in the assessment. The participant has communicated the assessment in a positive light, and by doing this successfully engages the client in an assessment.

In summary, therapists use a variety of methods to entice clients to engage in assessments. These methods are more than just considering which assessment will efficiently gather the information, but utilize the knowledge therapists have of the client to use tasks that are valued and meaningful to the client. This has shown to be successful strategy to engage clients in assessments. Many examples from the participants discussed an element of food within the assessments. This may be due to clients being able to relate to food and the culture of food within New Zealand. The next subtheme of Understanding the Person will be discussed.

Understanding the Person

As previously discussed, to engage a client in an assessment there needs to be a degree of rapport and development of the client-therapist relationship. Like any person meeting someone new, there needs to be time for sharing information and developing trust and understanding. Medical conditions and the impairments arising from them can have an impact on the client being able to engage in a cognitive assessment. The participants used sharing stories as a means to understand the client as well as trying to see the assessment from their point of view. Each of these will now be discussed.

When considering completing a cognitive assessment the therapist needs to take into account the condition of the client and what this means for the client. For example, a client who is particularly anxious may not easily cope with a cognitive assessment because it may heighten the level of anxiety. This may be compared to a client who has dementia and is not able to understand the reasoning behind the assessment due to limited insight. The example below outlines Tara's experience of completing a cognitive assessment with a client, which involved falsely explaining to the client that the assessment was required because a new staff member was being trained in using the assessment tool. Tara reasoned it was in the best interest for the client to not be fully informed on the actual reason for the assessment in which the client was engaging. Tara explains:

> *Usually quite willing. I mean, I did a Cognistat on a lady yesterday and I was a bit naughty and used the excuse I was trying to train up one of the new members of staff to use it, but that was because the lady suffers from anxiety and if she knew I was trying to assess her cognition, I felt that it wouldn't help her confidence because of the depression and anxiety so it was perhaps not an appropriate way of asking her to become involved…I felt it was important and she had a lot of problems completing it. She had to get up and walk around and we had to lots of breathing exercises through it and everything.*

Tara utilized strategies to continue with the client's engagement in an assessment process. This included, breathing exercises and walking around during the assessment. This example shows that therapists need to be aware of the effects assessments can have on clients even while trying to have the client's best interests at heart. Here, Tara acted on her knowledge that the level of the client's anxiety could impede her ability to engage in a cognitive assessment, using a level of deceit to secure her engagement. Tara acknowledged that her actions were not in accordance with the ethical requirement that clients be fully informed of the assessments in which they are engaging, but minimized the importance of that breach in framing her strategy as 'a bit naughty'.

Sydney also gave an account of a situation where there was a risk that a client might refuse to consent to an assessment. She gave an account of a client who had received feedback from medical staff, family and the village manager of his questionable ability to continue living at home. Sydney recognized that, given this history and that her visit would explore components of the client's life at home, his level of functioning, and what the outcome of this assessment might mean for his future, there was a risk of the client declining to engage in an assessment.

> *Because he had had feedback from the, they lived in a retirement village and the nurse at the retirement village had given them feedback that they weren't coping at home and they were really worried that she felt that they shouldn't be living in their unit any longer um, the family had given them feedback and the doctors had given them feedback and see everybody as threatening the status quo. And then I came along and threaten it too.*

Sydney has described the client's history in the lead up to receiving occupational therapy services because it could be perceived as threatening his ability to remain living in his home, therefore making him reluctant to engage. In detailing this history, Sydney shows there is a need to understand the background to any referral for assessment, that only by understanding the person's position, can the therapist approach him or her in a way that is likely to lead to consent to engage in an assessment.

Another participant discussed a strategy of spending time with clients to share information and stories, to gain a better understanding of the person and at the same time give some information about themselves. Sarah describes her experience of getting to know the person through the use of stories.

> *Used to go for walks together, um, often just spending time with her in her house, she found really useful because she was really lonely. Um, little bit of bribery sometimes, going out for a coffee you know that never goes astray. Go for a drive in the car, um, sort of things that she wouldn't ordinarily do. Um, there was a little bit of, um, you know giving a bit about myself and my back ground and sharing with her and finding those commonalities, however often this would be um, pretty destructible as well because of her complex presentation. Often the delusions would take over, um that rapport was often um, demolished sometimes, in terms of she would come to me yelling and screaming literally and throwing, not quite at the point of throwing things actually, although we have had damaged property. So you know, it would be up to me to de-escalate it which often so it would put me in the bad realm guy anyway, so her engagement with me over the coming days proceeding that would be really difficult.*

This example is from a mental health setting where there are concerning factors of the client's condition when developing the relationship. Sarah described her role when needing to redirect the situation and how this put the therapist in a difficult position within the relationship. By doing this, Sarah explained how she destroyed the rapport already established and then experienced difficulty with the client for a number of days

preceding the assessment event. This meant Sarah needed to re-build the relationship to be able to re-engage the client in assessments, which impacted on previous interventions and planning further assessments. Sarah described drawing on activities the client does not have the opportunity to do as a means of establishing rapport and gaining a better understanding of the client while doing this. Examples of this included spending time together, because the client was lonely, and using activities the client would find enjoyable, such as going out for coffee and driving.

Sydney discussed going one step further in telling stories with the client and family. This experience was described as an opportunity for the family to share their stories as well as an opportunity for the therapist to gather information from different sources about the client.

> *Often families tell me stories because once you start explaining what is cognitively happening with somebody with the family there, then they will tell you stories because they are going to, they get that information and they want to apply it to what they understand cause that is how they integrate it. So then they will tell you that this happened and that happened, the person did this and that. We talk about that and then clarify that so can you see how, how the reason they did that is because they weren't able to remember things about how to remember or when you talk to them about it they seem to make perfect sense to them and they understood everything you know, it was all fine, but then you know two hours later they have forgotten everything. So that's sort of, that's what happened. So they understand that the person will have some tangible evidence of something that they need to remember. So you know, so I think stories are really helpful because people relate to them, rather than um, hard test results.*

Sydney discussed what happens when she explains to client's families what is happening cognitively for the client after the assessment. In turn, the family has had the opportunity to tell stories when applying this information. The family and person are able to relate to the stories being discussed to gain a greater understanding of what is

happening for the client. Sydney explained through her experience that she feels stories are a beneficial way to gain an understanding of the client, because people can associate with this more successfully than giving black and white test results.

One component of understanding the person is what the therapist can do during the assessment to ensure the client is comfortable and willing to engage. Completing assessments within a mental health community setting, Sarah talked about what she can do, as the therapist, to ensure the client feels 'safe' during an assessment and continue to engage. This includes the recognition of age differences, between working with younger or older clients and what other people may think of two people together in the supermarket. Sarah gave this example of doing a shopping assessment.

> *He was a young guy, I think the most awkward thing for doing an observational assessment in the community is the internalised stigma that some people can feel because you know "I am a younger person perhaps and I am walking around the supermarket with an older person" or I'm, you know "how does that look to other people in the community?" So automatically there is two people in the supermarket that could be set apart.*

Sarah demonstrates there needs to be an awareness of these factors as it may affect the client's willingness to engage in an assessment. It is important to acknowledge the clients is a young guy and what stigma this may be perceived by the client in the community. Ken gave another example of reflecting on what it would be like in the client's situation. This example shows the consequences of using words such as *'cognitive assessment'* and *'check your memory';* that they have potential connotations for the client. Using this terminology can create stress and anxiety for the client, as they may not have considered their cognition to be a problem until someone has explicitly

mentioned this, therefore making the client reluctant to engage in a cognitive assessment.

> *Um, I was saying, they have lots of assessments in quick succession and there is a lot of personal information interchanged and you know, I will always put myself in their situations. I would be wondering why are all these people asking these questions for, do not, can they not read my notes, and what are they actually doing with these assessments, so when it comes time for a cognitive assessment and people hear the word "cognitive assessment" or "we are going to check your memory", they initially think "Oh my gosh, now they are going to find something that I know it is problem", or "I hadn't even thought anything was wrong with my memory" and people are reluctant to engage from there.*

Ken highlights frustrations and concerns often felt by clients faced by an assessment of their cognitive function. These include the client's lack of understanding of the reasons for the assessments, from the therapist not explaining the rationale behind the assessment, or the therapist questioning and the client trying to limit these questions about information that has already been collected in the clinical notes. Where lack of communication within the team results in repeat administration of a cognitive assessment, clients may have a decreased confidence in how the assessment outcome will be used and therefore become increasingly reluctant to engage.

The data also revealed that therapists have to use a variety of ways to understand the client while trying to engage him or her in an assessment. One therapist spoke about collaborating with the client on their perception that the assessment was *"stupid"* to encourage engagement in it. This is illustrated in the following example from Tara who has experienced trying to engage a client who was reluctant to participate.

> *They argue through it and especially if they can't do it, well "That's a stupid question, you know what are you asking this of me?" and you have to just drop yourself down and go "Look I know it's stupid. Can*

you please complete it for me?" and "I really need you to "and you just had to beg. And it's just hard work because it's just you know the time constraints with your job. You have put a certain amount of time aside, and you're spending a lot of time convincing them to do it and it's quite energy absorbing trying to convince a client to do it. But I realize for them it's difficult for them as well, because it shows them what they can and cannot do. So it's an emotional trip for them, but it's hard work when that happens and they get quite objective. They belittle the assessment and say it's stupid. And it's difficult because a lot of these assessment you know it's really hard for them to see how it relates to their everyday practice. You know, you are asking the questions like in the Cognistat, "What would you do if you were stuck in Auckland airport?" Blah blah blah, "well I wouldn't bloody be stuck there" and you know that but to get them to understand that's not what you are assessing. It's really difficult.

Tara acknowledged the frustration clients could feel while doing assessments. This may be due to the lack of understanding of the intent of the assessment, for instance in asking people to respond to a hypothetical situation by problem solving. Tara's account highlights the difficulties when using an assessment like the Cognistat that is not a specific occupational therapy standardized assessment, which needs to be completed in a certain way, and how a pen and paper assessment relates to the client's everyday life. Tara also raised an issue with time constraints within an in-patient setting, when clients are not willing to engage and the impact this can have on the clinical workload. Completing assessments when the client does not understand why they are being completed or cannot make sense of the test items does not encourage participation. This raises a concern in relation to the client having given informed consent, and at what time a therapist should discontinue an assessment because it is upsetting and stressful for the client. John gave another example from his experience of the types of behaviors clients exhibit when completing some cognitive assessments.

Another behavior I have noticed, with the MMSE or MEAMS [Middlesex Elderly Assessment of Mental State] um, people will be saying things like this is the lady her name is Mary Carter, I have not done this for years, but um, "Well she is nothing to me", you know, "I don't even like her",

you know. Or you know, they don't see the concept and they will just try and say, "No I am not going to remember her name, I don't even know her" and that kind of stuff.

Both John and Tara have discussed difficulties engaging clients in assessments such as the Cognistat, the MMSE and MEAMS, which are assessments that are not specific to occupational therapy. Therapists need to be aware of how formal assessments can be viewed by clients compared to functional assessments that focus on meaningful and familiar occupations, which are relevant to the client. Clients with cognitive impairments may not have the capability to generalize information to other situations or have the ability to see how formal assessments relate to everyday situations. Further to Tara and John's experiences of formal assessments, Edward discussed his experience of using an assessment to gain a better understanding of the client to assist in the future care of the client.

I sat down and I explained the activity, that was part of the assessment, my rationale to why I chose that um, I looked to explain to him that it was something that he would enjoy, something that he was capable of, I also suggested to him that what we were doing was not going to be a test. It was more of a way of understanding what we would do to help him in his future, and I also throw out that the findings of the assignment, of the assessment would be used for him, to possibly gain a place in a programme outside of the area, which is what he wanted. He jumped at the chance.

This experience from Edward shows how the information was presented to the client in a positive frame, which may have had an impact on how willing the client was to engage in the assessment. Edward also explained to the client the assessment was a task he would be capable of participating and would enjoy. Edward ensured the client was fully informed to what the task was, being familiar with the task and what the outcome of the task will inform. However, Edward has also suggested to the client the task was

not an assessment. The client could see the obvious benefit to doing what was asked of him and was therefore happy to engage.

In summary, therapists need to understand the client and the implications of their medical condition regardless of whether in a mental health setting or physical health setting. Therapists try and gain an understanding of where the person is coming from and use strategies of sharing stories to do this. Cognitive assessments can have an adverse effect on clients, which will change how willing they are to engage in the assessment process. Clients have shown to be willing to engage in occupation focused assessments that are familiar and relevant because they have more meaning compared to paper and pen type assessments. The participants' descriptions of using therapeutic communication will now be discussed.

Therapeutic Communication

The last subtheme that emerged from the data was the variety of communication styles used to support the client to engage in the assessment process and a belief from the therapist that the client was able to participate in the required assessment. The participants described the physical things they do within the client's environment if at home or hospital environment and the role of listening. The participants discussed using humour, and various other verbal and non-verbal communication styles with clients to promote engagement in the assessment process. Each of these will now be discussed.

The participants had a variety of ways to use utilize different communication skills to engage the client in an assessment. The first strategy was illustrated by Tara, who discussed providing verbal support and encouragement through an assessment. As Tara explains:

> *She just needed a lot of support to get through it really, verbal, you know prompting and support umm and time, giving her time so I guess that's the main thing with this assessment with her. It did take quite a large chunk of the day, to carry it out.*

Tara made time to answer questions and used prompting and verbal support to engage the client in the assessment. Further to verbal communication by means of support and encouragement, Tracey described another technique of remaining neutral when communicating with the client through the assessment. Tracey described using this technique so the client has a positive feeling within the client-therapist relationship.

> *And I do believe that it's, being respectful and not showing any irritation about the repeated things and those sorts of things and also getting other people on board so that when you are with that person, you get that other person on board with you, so they feel a good vibe. It doesn't always work.*

Tracey shows she is using key professional skills of respecting the client during an assessment and using a team and family approach. Tracey described working in collaboration with the person to effectively engage the client. Positive feedback has been shown to be an important component of the process to engage the client within assessments. Tracey demonstrated positive feedback targeted towards keeping the client motivated and engaged in the task. She also reported that it is essential for clients to receive feedback on their progress to assist with continual participation in the assessment. Tracey explains:

I find if someone starts ruminating or getting concerned about that area then that's when, you, they start. If they get a lot of no's, if they don't get positive feedback then they start getting antsy. What I do find with some people, quite a few people when you are doing any cognitive assessment with them they say, "Oh this is like being back at school". So you do sometimes have to do some conversation around why you are doing it, I do tend to use the doctor a bit, and I say well, "You might be suffering some effects from your antibiotics or your infection you have had or your um, medications, so we want to just get a nice baseline for you."

Tracey highlights that clients can become concerned without positive feedback or through lack of understanding of why the assessment is being completed. This is shown by the client starting to disengage from the assessment; Tracey then needs to spend time to reassure the client to continue engagement in the assessment. A strategy Tracey discussed using was to invoke the doctor requesting the assessment or requiring a *'baseline'* as a means to encourage the client to engage. Using another health professional as a reason for completing an occupational therapy assessment can take the ownership of the assessment away from the therapist, displacing responsibility onto a third party. The participant may do this to divert the negative feeling of engaging in the assessment away from him or herself. Using this approach highlights a concern that therapists may at times be uncomfortable working with clients who are upset or are difficult to engage in an assessment.

Adele described another example of how positive feedback can be used when someone is emotional and what strategies can be implemented to overcome this.

Um, some people with bad labiality, got quite teary towards the end because they don't think they have done as well as they have done. So, with that case sort of had to stop it and sort of give them [the client] a lot of coaching, motivational talk and those sorts of things. Luckily with that client she was happy to continue and then when I gave her feedback,

sort of during and you know towards the end she was happy with that and it made her feel better and she did not do as bad as she thought.

Adele demonstrates utilizing motivational talking and coaching the client if they have bad labiality to achieve successful engagement in the assessment. Clients can find completing assessments a stressful and emotional time. Adele shows that, due to uncertainty during the assessment and needing encouragement to continue and often completion of the task. These techniques can be used during informal assessments, however they may invalidate standardized assessments, when the therapist needs to adhere to the standardized procedure.

The next example from Tracey shows the relevance of using communication techniques of validation with the client and trying to work within the client's belief system. If this is not done or is challenged, the client may become aggressive while engaging in the assessment. Tracey explains.

> *Yeah, I found that you have to be respectful, you have to acknowledge the person and you have to, um, validate how they feel. So that it's no you don't. I find there is no point arguing with them if they think they are somewhere else and they aren't, because that's not their belief system, so whatever their belief system is. I have, I try to work within that. Um, yeah, otherwise you will just get someone that is aggressive and there's no point in telling them that they are not on the battle field of the song because of what they feel like, that's where they are. That is their reality, so we work through that and that's why I wait til I get some sort of normality and understanding before I start doing. So up until that point, I will just do practical things. I might take someone to make a cup of tea or those sorts of things.*

Again, Tracey shows she needed to respect the client and his or her belief system, even if medically unwell. Tracey has learnt not to engage in arguments with the client,

because this will make the client aggressive. Tracey uses functional tasks while the client settles into a routine on the ward and becomes medically stable and then the client can have a better understanding of the rationale for the assessment, which will assist with engaging in the assessment.

Alongside the strategies of different types of verbal communication, including motivational talk and positive feedback discussed by Tara, Adele and Tracey, there is also the use of non-verbal communication. Candice discussed her experience of reading non-verbal communication. This includes reading the client's body language and tone of voice. Candice explains that her role is to facilitate the client to find solutions and to try and create an environment that fosters problem solving.

> *It's based on how you are reading the situations and you are reading the other person's body language and tone of voice and things and just bearing in mind you know people are not rational beings. They won't always do what I think is right for them and I'm not here to control them and make them do what is right by my standards. I am just here to facilitate them to their own solutions. I have certain toolboxes and if they don't want to pick them up they don't have to, so I don't go in to fix anybody and I think that also helps, you know. That it is very much your responsibility as the patient to tell me what you are worried about and if I just suspect that I'm absolutely fine and I don't believe you, then I might, you know question around it just to raise some insight. Um, I don't take everything at face value by any means. (laugh) Um then yeah I will try and work on people's insight. It's trying to get the collaborative and give them protective the environment where they can say that this is a problem, rather than have to be defensive about it, so yeah.*

In this example, Candice shows her client-centred approach of the client being in control of the situation. Candice shows she needs to distinguish when clients' lack of insight into their functional limitations is impacting on the information collected and try to raise awareness around this with the client. Candice uses strategies of creating a safe

environment within a collaborative approach to explore limitations and engage in assessments.

Whereas Candice discussed her experience with body language, Sydney expressed the difficulties of reading situations during an assessment when interpreters are involved. Sydney felt she needs to watch behaviour when using interpreters, because she is unable to *'perceive and process'* when the client is not speaking English during the assessment.

> *Well of necessity the test is nowhere near as valid. I am just watching very carefully for behaviour to see that the behaviour is congruent with what ever the interpreter tells me because the trouble that the interpreter has got is that they are trying also to perceive and process what they think they hear and see. So you are always getting that second hand. Whereas when I am doing it with a patient myself often they speak English I'm doing the perceiving and processing of all the nuances. All the non-verbal cues and all the other stuff that you see. I'm doing whereas when the interpreter is involved there is a limit to how much I can do because I haven't got an understanding of the actual language so it's, it's more difficult.*

Sydney explains there are non-verbal cues that can be observed when completing assessments; however this is difficult when interpreters are involved. Therefore as the therapist, Sydney is reliant on the interpreter to interpret accurately because Sydney does not have an understanding of the language to understand whether the tone and body language of the client are congruent with what they are saying. Subtle cues may be missed when engaging this client group in assessments, due to being unable to understand the language and culture.

Further to non-verbal communication as discussed, Candice discussed her experience of what she can do physically in the client's environment when trying to engage the client. As she explained:

> *Um, well first of all I spend a bit more time than others often do, um, with people and I think that's important. I get down on their level, so I make sure that I am not having a conversation standing up from a great height. I pull up a chair and we have a chat, um. I usually pick up you know on things that are in their environment to draw their attention. They may have a card or got some flowers or family have just been or any things like that that we talk about to, to have that basic communication to make myself less intimidating really.*

Candice draws on cards or flowers within the room to start conversation and engage the client. Physically, Candice ensures she is *'down on their level'* by sitting on a chair which can start to create an equal partnership within the relationship and also a strategy to convey her therapeutic intent. By Candice sitting on a chair next to the client it shows the way the participant shares the power with the client who is engaging in the assessment. Candice describes wanting to spend the required amount of time with the client to begin building the relationship and recruiting the client's cooperation.

The last form of therapeutic communication that was discussed by the participants is the use of humour to successfully engage clients in the assessments. An example of using humour to engage clients with cognitive impairments in assessments was given by Sydney. She discussed the benefits of using humour so people can feel at ease and successfully engage. Sydney described her experience.

> *I use a lot of humour. A huge amount of humour. Um, my motto is that if we are not having fun then why are we doing this. And um, I think that is important that people, it's stressful enough as it is that anything that you can actually do to release some of the energy to allow them to you*

know let their valve off to some extent I think if really useful. I think that works, really well.

Sydney explains clients can present being stressed, when they are seen by an occupational therapist because they are in hospital. Aside from the reason a client is admitted to hospital, the environment and routines are different from their usual and often clients feel an amount of uncertainty while on the ward. Sydney now gives a specific case example of a client with whom she has worked and how she used humour during the assessment.

> *Well yesterday [I] had a lady in the ACE-R [Addenbrooke's Cognitive Examination – Revised] assessment as in some of the others, it asks you to generate as many words as you can starting with the letter 'P'. This person came up with the most amazing words that I had to think to spell properly and then they truly exhausted themselves by the time they came up with six of them. And I said "Wow those are really clever words, can think of some easy ones?" and the person just laughed as if desperate need to perform and their anxiety you know. "I'm happy with easy ones" and we both laughed and you could see the pressure coming off and um, yeah. In the assessment that is probably more difficult really. I do use it.*

Sydney's example clearly shows the anxiety and pressure clients can feel during an assessment. By Sydney affirming the client had done well so far during the assessment and using humour by means of a light hearted question that encouraged the client to laugh and then show relief in the situation.

Communication plays an imperative role in the relationship with the client to engage in the assessment process. The participants discussed their abilities to interpret body language and tone of voice when engaging in an occupational therapy assessment and utilizing strategies of positive feedback, motivational talk and coaching. The

participants used humour within assessments to foster engagement and in the language used when initiating engagement. Verbal and non-verbal communication skills are increasingly difficult to adapt to meet the clients need when using an interpreter during an assessment.

Summary: Recruiting Cooperation

The participants described a variety of ways to recruit the cooperation of the client to engage in an assessment. Therapists need skills and strategies to develop rapport with clients and select the most appropriate assessment for the client that is meaningful and relevant. The participants have shown to take an interest in being able to understand the clients as a person and that they need to understand their medical condition and how this may impact on the client's level of engagement. Many of the ways the participants engage clients in assessments arise from the therapist's tacit knowledge or what they have learnt through experience. Utilizing different communication skills plays an important role in verbal and non-verbal interactions between the client and therapist. Humour has shown to be a successful strategy to engage the client in a cognitive impairment particularly due to the stressful nature of assessments for the client. Further discussion of the findings in this study will be presented in the next chapter. This includes a synopsis of the findings, the relationship between the research and current literature, what's new and recommendations for practice, the occupational therapy profession and further research.

Chapter Six: Discussion

Introduction

The research question that I set out to explore was: How do occupational therapists engage adult clients with cognitive impairments in assessments? In this chapter I discuss the findings, relating them back to the literature, and identifying areas where my findings have aligned with previous studies and what is new from this research. Firstly, the synopsis of the findings will be presented. Secondly, the significance of the findings will be discussed and the limitations of this study. Finally, the recommendations for practice, the occupational therapy profession and further research will be presented.

Synopsis of Findings

At the outset of this study, I was interested in how other occupational therapists engage adult clients with cognitive impairments in assessments. By describing the experiences of nine occupational therapists, I have identified a range of considerations and strategies used when planning and initiating assessments. The first theme that emerged from the data called Managing Complex Process was the processes occupational therapists use, such as their procedural reasoning, applied to their step-by-step approach to assess clients with cognitive impairments. The second theme that emerged from the data was called Recruiting Cooperation. This addressed how the participants used the relationship with the client to engage in the assessment. A synopsis of each of these themes will now be presented.

The first step in any client interaction requires informed consent prior to engaging the client in the assessment. The participants used a variety of methods to obtain consent, and this was shaped by the context, with differences between mental health and physical health settings. Participants elicited consent by explaining their role as occupational therapists and the rationale behind why the assessment was required. The language used to convey the role of the occupational therapist needed to be pitched at a level that the client could understand. The participants did not use any formal processes to gain informed consent, which meant the main method was verbal consent. The role of the key worker was identified during the consent process and, at times, presented as a means to relay information from the therapist to the client, with consent being assumed from this. Participants tried to understand the client from their perspective, with an understanding that people may have a vested interest in the assessment findings.

The second step in the procedural reasoning process, as described by the participants, was preparation. The participants discussed needing to be flexible in their approach, taking the time to prepare the assessment required and ensuring the environment is setup appropriately. Participants had their own individual methods to start the preparation stage with clients. This includes the decision to complete formal or informal assessments versus functional assessments and the level of preparation required within community and inpatient settings. Within a community setting, the participants spoke about preferring easy to administer assessments compared with assessments that required preparation of the environment and tasks. Assessments tended to go 'wrong' when the participants were unprepared or the client was reluctant to engage in the assessment. For example, in an inpatient setting selecting the right time

of day or whether you complete the assessment with or without the family present had different outcomes on whether the client would engage in the assessment or not. Once the preparation is completed, the therapists move to initiating the assessment process.

The participants reported the need to initiate the assessment process when the client is medically ready to engage in the assessment, and monitored their cognitive status to determine readiness. This is the third step in the process that therapists enact. There are a number of factors that will influence the client's ability to engage in the assessment. He or she needs to be ready to participate, which means assessments being initiated at the right stage of their recovery. Consideration is also given to the client's current occupations and occupational history. The participants needed to be aware of how they elicit information and choose the right type of assessment that is appropriate for the client and their level of motivation to have the most success in engaging the client in the assessment.

The last step therapists take when engaging a client with a cognitive impairment in an assessment is to consider the potential impact of having a third party present during the assessment. The focus of any occupational therapy assessment is the client, however when assessing the client at home and in hospital, there is often a family member present or involved. Interpreters are another example of a third party being present when assessments are completed with people who do not speak English. The implications of having a third party present during the assessment is that they can impact on the client's level of attention and concentration during the assessment. There were differing opinions from the participants if there should be a third party present

during the assessment or whether the assessment should be completed with the client alone. Some participants felt there were benefits to having the family present because then an assessment could become a way to share information and an opportunity for the family to see how the client is functioning. Others felt that family could detract from the client's performance by distracting them, and therefore chose to not complete assessments in an inpatient setting during visiting hours when the client's family may be on the ward.

The second theme that emerged looked at the ways the participants used the client-therapist relationship to recruit cooperation of the client to engage in the assessment. Within the assessment process there are a number of strategies that therapists employ to develop the client-therapist relationship. An important interaction when engaging clients in a cognitive assessment is building rapport and recruiting the client to cooperate with the assessment process. The participants found that being an occupational therapist with the mindset of being solution focused can assist with developing the client-therapist relationship. Therapists can be seen as the link between hospital and home, and clients are therefore willing to listen to the solutions and engage in the assessments required to return home. The occupational therapist's own personal attributes also play a role in how the relationship develops and the use of pleasurable moments was successful in a mental health setting. However, there are risks within a mental health setting that, due to the client's medical condition, the relationship can be temporarily disrupted due to an episode and the therapist then needs to spend time to re-develop the rapport to reform the relationship.

Occupational therapists are trying to achieve a fit between the kind of person they perceive the client to be and the kind of assessment tasks in which they invite clients to engage and they strive to offer tasks clients will find meaningful. This concern seems to outweigh the concern for the integrity of formal assessments. To have the most success of assessing someone with a cognitive impairment a functional approach was utilized. The participants discussed the benefits when using a functional approach with clients and an activity that was meaningful to the client. Using this approach was shown to allow the client to participate at their best and sometimes shows surprising results.

The participants also discussed the importance of being able to understand the client as a person. A strategy to understand the client that was shown to be successful was the use of stories of themselves as a means to developing rapport. Clients needed to feel comfortable during the assessment. The participants discussed their experience of putting themselves in the client's situation to increase their understanding of the impact the assessment may have on them. This included the client being able to understand how standardized assessments can be generalized to everyday life. The participants discussed needing to give clear rationales as to how these assessments were relevant to everyday life.

Communication plays an important role in engaging the client in an assessment. The participants used a variety of verbal and non-verbal communication skills. There are things that therapists do physically within the client environment that can foster the development of the relationship, as well as observing body language through the

assessment for any signs of irritation or frustration. Positive feedback was used to motivate clients and enable them to fully engage in the assessment until completed. There was also a strong use of humour to engage the client within the assessment process, which was used to alleviate stress and anxiety for the client.

In summary, to be able to engage clients with cognitive impairments in assessments is a complex process. Figure 1 below, shows there are a number of factors that influence this process. Clients bring their previous medical history, roles, culture and occupational performance, while a therapist needs to consider a range of areas to engage the client within the process. The broad areas therapists need to consider prior to engaging a client in assessments are: communicating, managing the process, controlling third party presence, matching the client to the assessment and building rapport. Examples of how to use these strategies are given in each area. Therapists bring these complex areas together to collaborate with the client and recruit them to engage in an assessment.

Figure 1: Strategies to Engage the Client
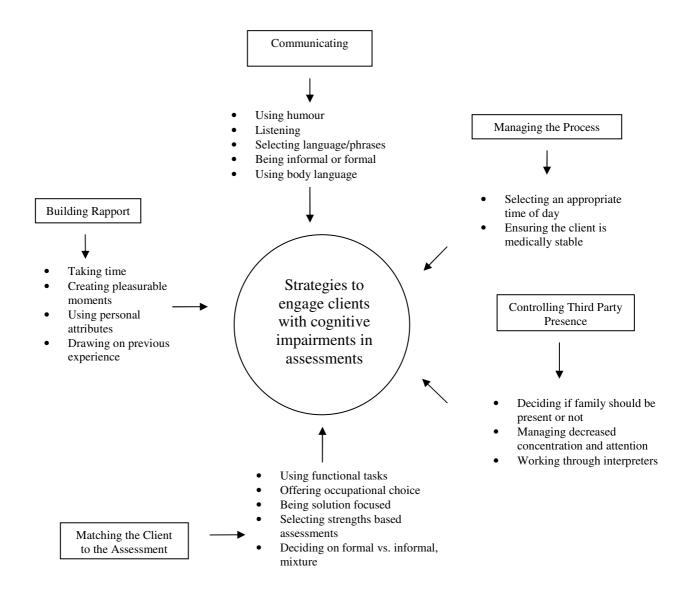
Relationship between the Findings and the Literature

This section discusses the relationship of the findings to the current literature available.

First the discussion turns to the relationship with interactive reasoning, therapeutic use

of self and the use of tacit knowledge. The role of humour will then be discussed and

lastly, the use of standardized assessments.

Mattingly and Fleming (1994) found that therapists use interactive reasoning to match the treatment goals and strategies to the person and collaboration is needed between the client and therapist to be able to achieve the outcome. Their work is consistent with the findings from this study, which revealed that assessments need to be relevant to the client, selecting assessments that are based on the client's strengths and deciding if a formal or informal approach would be best matched to the client.

On the basis of their ongoing research Mattingly and Fleming (1994) concluded that there is "strong evidence that the therapist's interest in building rapport with patients is linked to this need to gain the patient's cooperation" (p. 184). They discussed strategies to encourage collaboration that emerged through the findings of individualizing treatment sessions, being able to structure successful treatment sessions and exchanging personal stories. Participants within this study also utilized all of these strategies.

The findings are further supported by Taylor, Lee, Kielhofner, and Ketkar (2009) who found that the relationship between the client and therapist is vital to the client's engagement in activities and the outcome of therapy. The results in that study considered the therapeutic use of self as one of the most important skills in occupational therapy practice. This is in alignment with the participants in this study who tried to maintain the relationship when engaging clients in the assessment. The described role of therapeutic use of self in the occupational therapy literature, when communicating with clients is a valuable tool when interacting with clients, utilizing personal attributes

and focusing on the client as a person (Eriksson & Dahlin Ivanoff, 2002; Mattingly & Fleming, 1994) which was also found in this study.

Another thread from the occupational therapy literature relevant to this study is Fleming's (1994) acknowledgement that tacit knowledge is the base that forms our practice, which can be explained to as 'we can know more than we can tell' (Polanyi, 1966, as cited in Fleming, 1994, p. 24). Tacit knowledge has been evident within this study as the participants reflected and described their practice where there has been no clear processes put in place. The participants drew on knowledge and specific case examples to describe how they engage people with cognitive impairments in assessments.

A further relationship between the literature and this study is the use of humour in engaging clients in the occupational therapy process. This was shown by Vergeer and MacRae (1993), who described using humour as a holistic approach to occupational therapy that has been shown to be a particularly useful component when evaluating in the area of social, cognitive and psychological function. A study completed by Leber and Vanoli (2000) found that humour is a "valuable tool to help build rapport with clients and improve their response to therapy" (p. 225). This strategy has been evident in the findings of this study.

Finally, Holmqvist, Kamwendo and Ivarsson (2009) have reported occupational therapists' reluctance to use standardized assessments as well as uncertainty with the proper use of the assessments and communicating the results to the client. This was

also supported by Koh, Hoffman, Bennett, and McKenna (2009), who found that their participants relied more on clinical observations than the use of standardized assessments. The occupational therapists also described "the clients limitations as interwoven in occupational performance, leading to difficulties in assessing limitations separately" (Holmqvist et al., 2009, p. 20). The findings in this study showed a preference for informal assessments and deviation from the administration protocols where therapists perceived the therapeutic relationship with the client to be jeopardized by the requirements of the assessment process. Hobson (1996) reflected and explored the two strategies of graded decision-making and advocacy. Both strategies encouraged practicing in a client centred manner with clients who have a cognitive impairment from where obtaining informed consent is complex. Hobson's work also supports the findings of this study, in that the participants in this study also discussed the role of advocacy with this client group.

What's New?

Participants in the study described a snapshot of the complex processes employed to engage someone with a cognitive impairment in assessments. When engaging clients in assessments, there were distinct differences apparent between mental health and physical health settings. Within physical health settings, there is more of a focus on time constraints and a greater need to choose assessments that require minimal preparation within the community setting. Additionally, therapists in the inpatient physical health settings described how these settings provide opportunities for therapists to gauge when the client is medically stable and cognitively able to engage in the assessment, which was essential information in relation to obtaining accurate assessment results. Within a mental health setting there was an emphasis on doing

things that were 'pleasurable' and taking the time to listen and build rapport with clients, which was not evident within the physical setting.

Standardized assessments were used with a select group of clients who had a cognitive impairment. The participants knowingly selected sections of the assessments in order to engage the client in an assessment with a focus of utilizing his or her strengths. These sections of assessments were mixed with using functional assessments to compliment the information already collected and to continue engaging in the assessment process.

Participants tended to emphasise maintaining the therapeutic relationship. The strategies employed to that end included the therapists, at times, apologising for needing to complete the assessments in ways that shifted the responsibility away from the therapist. This occurred in relation to administering assessments that evaluated performance components rather than occupations. The participants also revealed vague processes of gaining informed consent, despite the knowledge that informed consent needs to be obtained prior to any client-therapist interaction. This lack of clarity and failure to enact expected processes may be attributable to the lack of the guidance from the occupational therapy or other health professions about how to elicit consent to engage people with cognitive impairment in therapeutic processes.

Strengths and Limitations

I believe this study, which explored how occupational therapists engage people with cognitive impairments in assessments, contributes to the body of occupational therapy knowledge. No one has looked at this research question before. The aim of this study

was to create a description of the occupational therapists' account and this was achieved using a qualitative descriptive approach. The analytic approach was rigorous and the findings are grounded in the words of the participants. The research approach was described in a step-by-step process, making it transparent.

This study has a small sample size and all participants are based in the North Island, therefore the sample may not be representative of all occupational therapists in New Zealand who work with clients who have a cognitive impairment. The small number of participants was within the boundaries of a Masters of Health Science thesis. The participants were from a range of settings including inpatient and community, mental health and physical health settings. There was also one participant who also worked in a private setting.

Over the course of the interviews, as the researcher, I increased my knowledge on the topic after the first couple of interviews. I was then able to refine my questions to gather a depth of information from the participants. Therefore the first couple of interviews were not as rich in information as the last interviews as I developed my skills as a researcher.

The data collected in the study relied on people to report their experiences of engaging people with cognitive impairments in assessments. If the design had incorporated observations, there may have been different results. The sample also only included occupational therapists, eliminating other disciplines and how they engage people with cognitive impairments in assessments.

Recommendations

For Practice

This study has a number of implications for practice. Firstly, the findings highlight that there are a variety of methods occupational therapists use to gain informed consent from clients, some quite informal. Organizations need to have a clear clinical pathway for obtaining informed consent from this vulnerable client group, because this issue is wider than occupational therapists. The findings showed that, at times, it was unclear if the client was fully aware that they were engaging in an assessment and what engaging in this assessment means.

Secondly, the participants discussed needing to use a variety of methods to engage a client in an assessment. This has been shown to be more complex than just considering which assessment will efficiently gather the information, which is what textbooks discuss in relation to selecting assessments. Individual practitioners needed to consider the context of the assessment (home versus hospital), the client's current medical status and previous level of occupational performance and the level of involvement from family to be able to successfully engage a client in an assessment.

Lastly, occupational therapists need to be aware that a strategy successfully used with one client may not be successful for another. The therapists need to spend time to get to know the person and gain a shared understanding of where the client is coming from.

For the Occupational Therapy Profession

Further research is required in the use of standardized assessments when assessing someone with a cognitive impairment. Therapists are aware of the benefits of using assessments for outcome measures, however participants in this study chose to complete functional assessments with components of standardized assessments, thus invalidating the standardized assessment. The assessment results are subsequently subjective rather than an objective initial assessment and are obtained at the expense of undermining the integrity of the assessments.

Another area for research is exploring the difficulties therapists have in engaging clients in assessments that are not based on occupations. The findings from this study show that therapists apologize for the assessment or point to other people, such as the doctor to shift responsibility for needing to complete the assessment. Rather than continue this practice, occupational therapists need to stand in their own professional expertise, because it appears they experience more difficulty engaging clients in assessments that are not specific to occupational therapy.

For Research

A replication of this study, utilizing an observational component with a larger sample size, is recommended. By observing the interactions between the therapist and the client, more information may be collected on the subtle and unspoken strategies that therapists use to engage clients in cognitive impairments.

In the absence of local and international literature, it would also be beneficial to find out what other strategies therapists are using in other countries to share experiences and build further knowledge in this area of practice.

Conclusion

This study set out to explore how occupational therapists engage adult clients with cognitive impairments in assessments. The findings have shown that therapists use a variety of strategies. The findings have not shown a clear method; rather therapists rely on their previous experience to know which assessment to employ and use their personal attributes to engage individuals in assessment processes. In this, they prioritize their relationship with the person to be assessed, at the cost of clear consent processes and the integrity of formal assessments. These findings have implications for practice settings, the occupational therapy profession and future research.

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Appendices

Appendix A: Ethics Approval

AUT
UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

M E M O R A N D U M
Auckland University of Technology Ethics Committee (AUTEC)

To: Clare Hocking
From: **Madeline Banda** Executive Secretary, AUTEC
Date: 29 January 2010
Subject: Ethics Application Number 09/290 **How occupational therapists engage people with cognitive impairments in assessments: A descriptive study.**

Dear Clare

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 14 December 2009 and that I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 8 February 2010.

Your ethics application is approved for a period of three years until 29 January 2013.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through *http://www.aut.ac.nz/research/research-ethics*. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 29 January 2013;

- A brief report on the status of the project using form EA3, which is available online through *http://www.aut.ac.nz/research/research-ethics*. This report is to be submitted either when the approval expires on 29 January 2013 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring

that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organization for your research, then you will need to make the arrangements necessary to obtain this.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Amanda White amanda_bishop_@hotmail.com

Appendix B: Participant Information

Project Title
How occupational therapists engage people with cognitive impairments in assessments: A descriptive study.

An Invitation
You are invited to take part in a study that explores how occupational therapists engage people with cognitive impairments in occupational therapy assessments.

Who am I?
My name is Amanda White and I am an occupational therapist. I have worked in a variety of settings within physical health. I am currently enrolled in the Masters of Health Science programme at Auckland University of Technology. As part of the requirements of this course, I am conducting research for my thesis. Participation in the study is completely voluntary and you may withdraw at any time without any adverse consequences.

What is the purpose of this research?
The purpose of this study is to investigate what occupational therapists do to engage people with cognitive impairments in assessment processes. As therapists we select and provide assessments to this client group but there is limited research to demonstrate how occupational therapists respond to the needs of people with cognitive impairment.

What will happen in this research?
We will arrange an interview at a place and time that is convenient to you. The interview will be approximately 1 hour. It is possible that I may wish to interview you a second time to gather further information or clarify something you said. You will be asked to tell me your experiences when completing assessments with people who have a cognitive impairment. The interviews will be audio taped and then transcribed. Themes from the information will be collated.

Have Maori been consulted?
I have spoken with a Maori Research Advisor during the initial phases of this study. You are welcome to bring a support person to the interview and be involved in the research process. If any participants identify as Maori, the Maori Research Advisor will be consulted in relation to the interpretation and reporting of findings.

What are the discomforts and risks?
I do not anticipate any risks to you from participating in this study. However if you do feel uncomfortable or upset at any time during the interview you can ask that the interview be stopped. As you will be talking about your experiences in practice, if you disclose any information you later regret, you have the right to instruct me to delete these from the transcript. If any evidence of unsafe or unethical practice arose during this study, I will discuss these with you and if required discuss the need to disclose this information to your relevant manager in accordance with the New Zealand Occupational Therapy Board Code of Ethics (2004).

What are the benefits?

There will be little direct benefit to participants, but occupational therapy service provision may be enhanced if good practice is uncovered and described, or if issues are bought to the profession's attention to be addressed.

How will my privacy be protected?

The tapes and transcripts will be confidential to me, my supervisors and the typist transcribing the interviews. The typist will sign a confidentiality agreement. A pseudonym will be used to protect your identity on all materials. The audiotapes and transcripts will be kept for 6 years after the study's completion then destroyed.

What are the costs of participating in this research?

The cost to participating in this research is your time. This includes completing the interview and potential follow up discussion. The interview may take 60 minutes and the follow up discussion 30 minutes. I will send you a copy of the transcripts for you to check.

What opportunity do I have to consider this invitation?

I appreciate you taking the time to read this information and considering being a participant in the study. If you would like to participate in the study it will be good to hear from you. Please contact me within 2 weeks of receiving this information sheet, your involvement is entirely voluntary.

How do I agree to participate in this research?

If you would like to participate in the study please contact me by email amabis01@aut.ac.nz. You are welcome to ask further questions before agreeing to this. When we first meet we will go through the consent form, which will be signed prior to the interview.

Will I receive feedback on the results of this research?

The final research report will be available as a master's thesis in the Auckland University of Technology library. Any articles relating to the research will be published in relevant journals. The research findings will be presented at seminars. At the end of the research a report about the research will be posted out to you.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Clare Hocking, *clare.hocking@aut.ac.nz*, (09) 921 9162.
Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, *madeline.banda@aut.ac.nz* , 921 9999 ext 8044.

Whom do I contact for further information about this research?
Researcher Contact Details:

Amanda White, Master of Health Science Student, Auckland University of Technology, Akoranga Campus, Auckland, amabis01@aut.ac.nz.

Project Supervisor Contact Details:

Clare Hocking, Department of Occupational Science and Therapy, Auckland University of Technology, ph (09) 921 9162.

Approved by the Auckland University of Technology Ethics Committee on 29th January 2010 AUTEC Reference number 09/290

Appendix C: Consent Form

Consent to Participate in Research

Project title:	How occupational therapists engage people with cognitive impairments in assessments: A descriptive study.
Project Supervisor:	Clare Hocking and Heleen Blijlevens
Researcher:	Amanda White

○   I have read and understood the information provided about this research project in the Information Sheet dated 29 October 2009.

○   I have had an opportunity to ask questions and to have them answered.

○   I understand that notes will be taken during the interviews and that they will also be audio taped and transcribed.

○   I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○   If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

○   I agree to take part in this research.

○   I wish to receive a copy of the report from the research (please tick one): Yes○ No○

Participants signature: ....

Participants name: ....

Participants contact details:

…………………………………………………………………………………..

…………………………………………………………………………………..

…………………………………………………………………………………..

…………………………………………………………………………………..

Date: ....

Approved by the Auckland University of Technology Ethics Committee on 29th January 2010 AUTEC Reference number 09/290

Note: The Participant should retain a copy of this form

Appendix D: Demographic Data

Prospective Participant Demographic Data

Name: ....

Contact details: ....
....
....
....

Gender: Male   Female (circle answer)

Ethnicity: ....

Years of practice: ....

Practice setting (e.g. acute inpatients):...

Current: .... Length of time in practice setting: ....

Previously: .... Length of time in practice setting: ....

Assessments used with people who have cognitive impairments:

Formal assessments used: ....
....
....

Informal assessments used: ....
....
....

Appendix E: Interview Schedule

Interview question format

Warm up/Introductions

Introduction on research topic

Agenda of topics

Can you tell me about a referral you received to assess someone with a cognitive impairment?

Can you describe your initial thoughts regarding the referral?

How did you contact the person to visit them at home?

Can you tell me about how the assessment was completed?

How did you select this type of assessment?

Would have anything been different if a family member/friend was present/not present? If so, how?

Can you tell me about a time that an assessment has not gone according to plan…/gone unexpectedly well..

Tell me about a time that you had difficulty engaging a person who has a cognitive impairment? What did you do? What did you say?

How do you explain the outcome of your assessment to the client/family?

What did you do with the assessment results?

Using prompting questions of:

What made you choose to do that…….

Was there another way that you would of done that if it happened again?

Can you tell me more about…..

What did that mean for you?

How did that make you feel?

Closing

Check is anything else the participant would like to comment on

Thank you for participation.