Virtual Visitation: Promoting Social Occupations in Dementia Care

By

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Abstract

Approximately two thirds of skilled nursing facilities (SNFs) residents in the United States have some form of cognitive impairment such as dementia (Gaugler, et.al, 2014). Care practices in SNFs highlighting safety and therapeutic exercises may further isolate and decrease social opportunities, which can contribute to sensory deprivation in this population and result in lower quality of life (Haigh & Mytton, 2015; Nakamae et al., 2014). COVID-19 visitation restrictions, as well as ongoing barriers of geographical distance, present additional challenges when seeking to engage PLwD residing in SNFs in meaningful social occupations.

Reminiscence has potential to remediate effects of isolation and sensory deprivation among PLwD. (Nakamae et al., 2014) (Lohda & De Sousa, 2019). Ouslander & Grabowski (2020) have looked to virtual visitation as a potential modality to enhance social engagement and minimize physical barriers to visitation for PLwD. With approximately 20% of OTs and 56% of OTAs working in SNFs, occupational therapy practitioners (OTPs) have the opportunity to play a critical role in facilitating engagement in social participation (AOTA, 2015; Rafeedie et al., 2018). The Supported Family Visit through Reminiscence (SFVR) intervention is a tool designed to support OTPs in facilitating virtual reminiscence-based visits for PLwD and their loved ones.

The SFVR utilizes a visitation template that is populated with pictures, music, and videos in order to elicit long-term memories that will enhance engagement between the PLwD and visitor. With specific training on dementia, OTPs are in a unique position to promote engagement of social occupations among PLwD in SNFs. By expanding their scope of practice within SNFs, OTPs have the potential to contribute to the remodeling of the culture in SNFs and increase the focus on meaningful interactions, including those that address social occupations (Rafeedie et al., 2018).

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Section I**Proposal**

Introduction

Dementia is a condition that is characterized by neurocognitive decline due to abnormal brain changes and is related to a number of specific medical conditions, including Alzheimer's disease (Alzheimer's Association, 2019). This decline in cognitive skills impacts daily life and independent function (Alzheimer's Association, 2019). The body of evidence available today indicates a strong correlation between the condition of dementia and declining quality of life (QoL) (Jo & Song, 2015). Diminished QoL for people living with dementia (PLwD) can result from psychological and environmental factors such as loneliness and sensory deprivation (Victor et al., 2020). Sensory deprivation is defined as the inability to obtain the amount and type of sensory input one needs, and the degree to which this causes harm to the nervous system (Champagne, 2018). As the novel coronavirus (COVID-19) sweeps the globe, there is a heightened concern regarding the QoL of PLwD in SNFs due to visitation restrictions' exacerbating effect on the aforementioned factors of loneliness and sensory deprivation. Additionally, geographical distance between visitors and PLwD is an ongoing permanent barrier to regular in-person visitation, further contributing to the detrimental effects of these factors.

Raffeedie et. al (2018) asserts that "occupational therapy's scope of practice, if fully utilized and effectively implemented, can be the solution to the challenges described in today's nursing facilities" (p. 2). In an effort to remediate the consequences of loneliness and sensory deprivation, occupational therapy (OT) practitioners have an opportunity to support social occupations for PLwD in SNFs. The Occupational Therapy Practice Framework, 4th edition, delineates social participation as activities including family, friends, peers, and community members that support social interdependence (AOTA, 2020). Though the COVID-19 pandemic may prevent in-person social participation at this time, OTs can engage PLwD in adapted social

interactions with family or friends using a virtual platform. Thus, virtual visitation may be a feasible intervention to support social occupations in PLwD.

Despite the cognitive impairments characteristic of dementia, PLwD may be able to engage on a virtual platform in personalized reminiscence with the support of trained family and friends. The theory of Social Relational Engagement (SRE) posits that though arbitrary volunteers are able to provide social contact for PLwD, visits are more poignant and impactful in eliciting successful communication from residents when they are made by family or close friends (Walmsley & McCormack, 2017). To that end, this project will create a reminiscence-based intervention that OT practitioners can incorporate into their practice to support family and friends in meaningful and dementia-appropriate virtual visits. This type of semi-structured visit will henceforth be referred to as the Supported Family Visit through Reminiscence, or SFVR.

Currently, there exists a lack of focus on socialization in SNF-based OT practice as the general clinical practices and culture in SNFs instead prioritize resident safety and management of medical conditions. Instances of confinement are sometimes used with residents to ensure safety, resulting in decreased sensory input, decreased perceptual skills, and increased withdrawal for the PLwD (AOTA, 2017). A novel and structured tool such as the SFVR will empower OTs to utilize their full scope of practice to promote socialization among PLwD, thus supporting culture change. In SNFs.. Through the use of an instructional web-based training module, SNF OTs will be trained in the implementation of semi-structured visits that incorporate reminiscence strategies for PLwD and their loved ones. The SFVR supports meaningful communication between PLwD and their loved ones and is a tool for OTs to utilize when promoting social occupations for PLwD.

Background and Review of the Literature

Dementia

Dementia is a group of symptoms characterized by a decline in memory and faculty of thought with related impairment of functional activities, including activities of daily living (ADLs) and Instrumental activities of daily living (IADLs), thus impairing independence. Independence is further diminished by impairments in language and psychological and psychiatric function (Laver, Clemson, Bennett, Lannin, & Brodaty, 2014). The aforementioned effects of dementia lead to frustrating difficulties and failures not only in ADLs and IADLs, but also in socialization, relationship maintenance, and leisure occupations. This not only impacts the PLwD, but also their family and friends (Frankenstein & Jahn, 2020). The World Health Organization (2020) asserts that there are currently around 50 million people worldwide who live with dementia, with 10 million new cases projected each year. As such, dementia has been identified as a public health priority by the World Health Organization (2020).

The clinical presentation of dementia is varied and unique to each individual. Despite this variability, the signs and symptoms linked to dementia can be understood in three stages: early, middle, and late. Early stage is sometimes unrecognized as dementia by families as memory loss can be mistaken for normal aged forgetfulness (Reisberg, 1984). Symptoms of early stage dementia may be subtle and can include forgetfulness, losing track of time, decreased problem solving, and becoming lost in familiar places. Issues with safety, judgement, and insight are also apparent. Remaining abilities for early stage dementia include maintaining attention for 20-60 minutes, ability to function well with routines and old habits, and strong verbal skills (Allen et al., 1998). Signs and symptoms of middle stage are apparent in everyday functional activities, are more easily recognized by family members, and include forgetfulness of recent events, becoming

lost at home, and difficulty in communication (Fisher Center for Alzheimer's Research Foundation, 2021). In middle stage, PLwD are able to follow simple directions, communicate with simple phrases, perform routine activities with cues to sequence the steps, and can perform manual actions with their hands and objects (Allen et al., 1998). Late stage is characterized by a lack of awareness of time and place, difficulty recognizing relatives, and increased need for assisted self-care (World Health Organization, 2020). Remaining abilities in late stage dementia include participation in self feeding, gross motor movement and communication through simple verbalizations (Allen et al., 1998).

The Alzheimer's Association (2019) explains that individuals experiencing early stage dementia respond well to occupation-based interventions. As dementia progresses to middle and later stages, however, more support is required to engage individuals in these types of interventions. Towards the end of the progression of the disease, family members may initiate the transition to a supportive environment such as a skilled nursing facility (SNF).

Individuals with Dementia Residing in SNFs

In the United States, PLwD are four times more likely to receive care in a SNF than someone without a cognitive impairment (Borda et al., 2020). Cognitive impairments in PLwD limit everyday functioning, leading to increased dependency and the need for services provided by SNFs (Borda et al., 2020). In SNFs, PLwD may disengage from previously enjoyed activities and relationships and thus experience social isolation, boredom, and restlessness (Douglas & Affoo, 2019).

Providing care to PLwD in SNFs requires knowledge and skills to address the medical, physical, cognitive aspects of care as well as sensitivity to the interpersonal needs of the residents and their families. The number of dementia care units has increased over the past 10

years. These specialized units within SNFs have structural design, staffing, and activity programs intended to provide a supportive social and physical environment for PLwD (Cadigan, Grabowski, Givens, & Mitchell, 2012). To improve the quality of care for PLwD, SNFs have implemented person-centered care, involved family members, carers, and volunteers, reduced the use of psychotropic drugs, and utilized a multidisciplinary approach to rehabilitation (Prins, Willemse, Heijkants & Pot, 2019).

Contributing Factors of Decreased QoL for PLwD: Loneliness and Sensory Deprivation

Despite efforts to enhance the QoL, decreased opportunities for meaningful communication and social engagement in SNFs lead to loneliness and sensory deprivation among PLwD, two main contributing factors leading to decreased QoL in this population (Haigh & Mytton, 2015; Nakamae et al., 2014). This is an especially relevant issue in the face of COVID-19 related visitation restrictions, highlighting the need for the promotion of social occupations (Tyrrell, 2020). A pattern of loneliness among PLwD in SNFs is reflected in contemporary OT literature. The Dementia and Enhancing Active Life (IDEAL) cohort study explored the connection between social engagement and QoL. Researchers interviewed 1,547 mild to moderate level PLwD living in the community and found that 30.1% were moderately lonely, while 5.2% were severely lonely. Depressive symptoms as well as risk of social isolation were both associated with loneliness (Victor et al., 2020). These findings are significant as the prevalence of depressive symptoms among PLwD is estimated at 50% by some experts (Nakamae et al., 2014).

In addition to the risk posed by social isolation, sensory deprivation is another significant threat to QoL in PLwD. Described as the inability to integrate sensory information and the degree to which this causes harm, sensory deprivation is commonly seen in PLwD and may be

prevalent in SNFs due, in part, to pervasive confinement (Champagne, 2018; Steel et al., 2020). Confinement may be motivated by efforts to maximize safety for residents and can include locked wards and limited access in and out of SNF facilities. In some instances, residents may be “parked,” with a table in front of the individual, or they may be put in a reclining chair in order to restrict movement (Steel et al., 2020). These practices deprive PLwD from necessary sensory input, and the individual may withdraw further into themselves. As a result, decreased perceptual skills and inadequate occupational performance arise, thus leading to a lowered QoL (AOTA, 2017).

Nonpharmacological interventions, including reminiscence therapy, are more effective than pharmacological approaches in treating depression for PLwD and come with fewer side effects (Park et al., 2019). To this end, occupation-based interventions that support social engagement, such as reminiscence, must be considered for their ability to minimize loneliness and promote sensory experiences. It may be useful to engage family and friends of PLwD in the promotion of social engagement via reminiscence to remediate these factors.

Reminiscence to Improve Communication and Decrease Sensory Deprivation in PLwD

Interventions to address loneliness at the individual, group, and population levels are valuable ways to enhance QoL (Day, Gould, & Hazelby, 2020). Evidence-based interventions include home visits from members of the community, telephone and visual calls from family and friends, support groups to address specific age-related concerns, and community-based group activities such as gardening (Day, Gould & Hazelby, 2020). Reminiscence therapy (RT) is another intervention that has the potential to remediate effects of isolation and sensory deprivation among PLwD, making this approach one of the most popular psychosocial interventions in dementia care (Lohda & De Sousa, 2019). It is recommended that RT

interventions should be included in care, not just by SNF staff, but also family members and care providers (Lohda & De Sousa, 2019).

Reminiscence is a non-pharmacological intervention commonly used in dementia management as a means to improve QoL and promote communication. RT is the process of recalling personal events or experiences that are memorable to the individual, allowing them to rely on more easily accessible long-term memories (Dempsey et al., 2014). Day, Gould, & Hazelby (2020) note that social isolation can result in poor physical and mental health, and even premature mortality. Therefore, visits by loved ones may hold promise for reducing loneliness and increasing QoL, as well as improving overall physical health and longevity (Walmsley & McCormack, 2017). Continued engagement in familial bonds lead to positive interactional patterns (Walmsley & McCormack, 2017).

Social Relational Engagement (SRE): The Importance of Familiarity

Given that social interaction can promote psychological well-being and a clear sense of self, Sabat (2005) suggests that PLwD ought to maintain meaningful relationships and interactions with others. Though outside volunteers are able to provide social contact for PLwD, visits are more poignant and impactful when they are made by the resident's family or close friends. This assertion is supported through the theory of Social Relational Engagement (SRE), which describes interactional patterns as embedded in familial bonds (Walmsley & McCormack, 2017). Walmsley & McCormack (2017) qualitatively investigated the evidence of retained social awareness in PLwD residing in care-homes when engaged in interactive family visits. Results demonstrated that family visits are more powerful than visits with volunteers or staff for PLwD in care homes due to their increased ability to stimulate cognition, social engagement, and emotion. When visiting with the family group, PLwD “responded creatively to losses in speech

through communicative and expressive voice, facial, and body gestures” otherwise unapparent outside of the familial interaction (p. 961). The absence of the PLwD’s “creative response” in interactions with staff or visitors may be an inherent side-effect of communication with an unfamiliar person, as they are unable to pull from historical knowledge of the PLwD to guide the interaction (Walmsley & McCormack, 2017). Thus, the theory of SRE highlights the importance of communication for PLwD that is marked by “intimate, familiar, and distinctive relationships” so that these individuals may demonstrate optimal awareness and engagement (p. 961).

Communication Dynamics and Their Impact on PLwD

Communication is a dynamic and complex process which greatly impacts social engagement and sensory experiences among PLwD. When thought of in this way, factors such as body language, intention, and cognition each need to be considered by the conversation partner of the PLwD. A PLwD is likely to have difficulties in many aspects of the communication process, including their understanding of what is being said to them, their speaking fluency, comprehension, word production, syntax and verbal feedback (Banovic et al., 2018). However, nonverbal communication such as their understanding of facial expressions and use of gestures remains accessible throughout the disease progression. As such, communication that occurs with PLwD necessitates a shift in roles; no longer an even and reciprocal process, the other participant (often a family member or friend), must learn to adapt to the specific needs of the PLwD (Jootun & McGhee, 2010). This adaptation can be facilitated by the participant having a more thorough understanding of how PLwD typically communicate as they progress through the disease.

According to Jootun and McGhee (2010), 93% of communication that occurs between neurologically unimpaired individuals is nonverbal, and of that 93%, 38% is associated with vocal tone and volume, while 55% is body language. Jootun and McGhee (2010) further explain

that communication is a cyclical process and the successful relay of information between speaker and listener is dependent on all participants sharing a common understanding of the sociocultural context in which the message is being delivered. When the message is first presented by the speaker, the words selected, the tone in which they are said, and the body language displayed must be “encoded” with the sociocultural context if the listener is to adequately “decode” the message and provide appropriate feedback. If this encoding and decoding process is not able to occur, the meaning is easily lost and effective communication is much more difficult to achieve. Furthermore, Banovic et al. (2018), examine the progression of linguistic deficits for PLwD. Often the loss of language is the first symptom to be noticed and presents as difficulty with word finding, incorrect word use, and eventually an inability to recall names and recognize family and friends. More specifically, Banovic et al. (2018) state PLwD will “use less words, less common words, less prepositional phrases, less dependent clauses, and more incomplete fragmented sentences” (p. 222). In order to enhance the communication experience between a PLwD and their speaking partner, Banovic et al. (2018) suggest: PLwD should always be addressed from the front and the communication partner should utilize tactile cueing (e.g. a touch of the hand), provide a calm distraction free environment, use simple language and speak slowly, speak to the PLwD as an adult, give ample processing time, use pictures or other visual cueing strategies (e.g. hand gestures, physical items, writing words out for them to select), and refrain from correcting mistakes. Because of the complex nature of communication and the specific communication needs of this population, PLwD struggle to have meaningful, effective, and pleasant interactions with those around them (Jootun & McGhee, 2010). These impaired performance skills related to communication deficits inhibit successful social interaction among PLwD (AOTA, 2020). With this in mind, there is added value in social interactions and communication occurring in a context

that supports the display of non-verbal communication by a PLwD, such as an in person visit or via a virtual format.

Impact on Communication for PLwD

Research indicates that family and friends experience difficulties when communicating with PLwD (Riachi, 2018). PLwD will often display language deficits early on in the progression of the disease, struggling to remember words, names, or connections between concepts (Jootun & McGhee, 2010). These language impairments ultimately impact the speaker's (PLwD) ability to encode their message with meaning and context, reducing their listener's ability to comprehend what is really being said. As these deficits become more pronounced, communication becomes an anxiety laden experience for PLwD and an emotionally draining one for the other participant(s) (Riachi, 2018). Educating family and loved ones through the facilitation of dementia appropriate social interactions could provide the context necessary for effective and meaningful communication, ultimately leading to a successful encoding and decoding of messages between PLwD and their visitor, resulting in a positive social interaction.

To equip family members with knowledge and strategies for effective communication is to support a greater QoL for the PLwD. As memory, problem solving, and orientation diminishes for PLwD, family members may start to view a PLwD as less capable, possessing less agency, and as a safety risk to themselves or others (Steel et al., 2020). As PLwD become more impaired, they cannot effectively communicate their needs and desires, resulting in behaviors that are deemed inappropriate or problematic. This is a cyclical process: poor communication leads to increased problematic behaviors, and thus to increased isolation from what is familiar and meaningful. With a clearer understanding of how to communicate with PLwD, as well as strategies to determine their unmet needs, it may be possible to enhance QoL for PLwD.

Prior to visitation restrictions due to COVID-19, the primary form of communication technology used by PLwD in SNFs to remotely connect with family and friends had been the telephone. However, as this communication tool does not allow for effective non-verbal communication strategies to be utilized (such as visual cues or facial expressions), it is challenging for the caller to provide an appropriate level of stimulation to engage a resident with dementia, becoming yet another barrier for communication between the PLwD and their loved ones. Researchers have begun to explore how communication via video platforms may be used as a more effective alternative form of remote communication for SNF residents, and nascent benefits have been shown in terms of reduced loneliness and depression, and increased closeness and enjoyment (Moyle et al., 2020).

Technology Assisted Social Interactions

Impact of COVID-19 on Access to Social Interactions for PLwD

Across the nation, SNFs have limited visitor and volunteer presence to prevent transmission of COVID-19 to residents who are a compromised population (CMS, 2020). As a result, PLwD have been cut off from the outside world, their loved ones, and opportunities for meaningful communication and social interaction. Public health orders that fully restrict in-person visitation lead to increased isolation and sensory deprivation among PLwD (CMS, 2020). One way to address these risks is to transition visitation to a virtual platform. Technological advances have increased access to healthcare, facilitated communication, and enabled meaningful participation in society for adults aged 65 years and older (Lee & Kim, 2019). In response to the COVID-19 visitor restrictions SNFs have utilized technology to facilitate meaningful social engagement for their residents. Enriching the lives of their residents in this way has the power to improve overall QoL and reduce the negative impact social isolation can

have on an individual's well-being. Through the use of virtual platforms, it is possible to incorporate and facilitate evidence-based interventions, such as RT, during video calls (Ouslander & Grabowski, 2020). The use of technology for visitation could allow for increased interaction and facilitate communication between PLwD and loved ones.

Virtual Platforms and Reminiscence Therapy

Technology assisted RT on a digital platform will create opportunities for social interactions between PLwD and virtual visitors, namely family and friends. Conventional RT may include many methods of reminiscence. Most commonly, this process involves storytelling with the use of “memory triggers,” which may be household items or objects related to the individuals’ past (Moon & Park, 2020). However, a digital approach can allow for deliverance of additional engaging media such as computer graphics, audio, personalized videos, digital photos, and webcam interactions (Moon & Park, 2020). Moon and Park (2020) conducted a pilot randomized controlled trial comparing the effect of digital RT to a non digital conventional RT on PLwD. The study enrolled 49 PLwD with 25 people receiving the digital RT and 24 PLwD receiving the storytelling. The digital RT included an Android application and pre-loaded media as well as added personalized material. Both groups received 8 sessions over the course of 4 weeks. The study measured cognition, depression, behavioral and psychological symptoms before and after the intervention and engagement on the first and last session. Depression was found to be significantly decreased and engagement significantly increased in the digital RT group compared to the control group. No changes were noticed in cognition or behavioral symptoms, consistent with the progressive nature of dementia. In addition, researchers identified how a digital format for RT increases accessibility due to the convenience of easily uploading digital photos and music onto phones without special equipment, the stronger visual and audio

stimuli digital media provides, and the ease of using personalized content in the app (Moon & Park, 2020). These findings suggest that digital RT can help improve mood and increase the opportunities for social interactions among PLwD (Moon & Park, 2020).

Moon & Park (2020) demonstrate that technology can provide a bridge to support social interactions between PLwD and family members. The number of PLwD is estimated to grow to 74.4 million worldwide by the year 2030 (Astell & Smith, 2018). This estimate only accounts for PLwD and not the entirety of those impacted by this disease, including family members and caregivers. Using technology to support this population and those impacted by it, is highly important to mitigate social isolation. Two other studies, conducted by Astell & Smith (2018, 2018), investigated the use of information and communication technologies to support communication abilities of PLwD. Astell & Smith (2018) looked at the efficacy of a specific technology, the Computer Interactive Reminiscence and Conversation Aid (CIRCA), a software and computer interface tool used for the delivery of digital RT. CIRCA is an application intended to support communication between a PLwD and their caregiver utilizing various reminiscence strategies that engage the individual's long-term memory by way of music, photos and videos (Astell & Smith, 2018). Another study conducted by Astell et al. (2018), examined the use of CIRCA as a group intervention for PLwD attending a day program in Sheffield, UK. With a 2000 item database, the participants were able to engage with the application two times a week for seven weeks, viewing generic items related to childhood, entertainment, sports, people, and places (Astell et al., 2018). While the items available through the CIRCA application were not personalized, they were intended to be familiar and residents were able to select items independently. The outcome measure used in this study was the Addenbrooke's Cognitive Examination-III, which covers 5 domains, including attention, memory, fluency, language, and

visuospatial (Astell et al., 2018). Additionally, this study utilized The QoL in Alzheimer's Disease scale to measure QoL and the EuroQol five-dimensions scale to measure health status (Astell et al., 2018). While there was no significant improvement in health status, results of this study indicate improvements in cognition and QoL. This study is an important stepping stone in understanding the utilization of technology in dementia care as it points to the efficacy of RT deliverance via an electronic format, as well as ease of use for caregivers and healthcare staff. Furthermore, the success of this study in a group setting is valuable, as individual one-on-one sessions may be hard to coordinate due to patient load and insurance guidelines that exist in many SNFs. The primary limitation of this study is the small sample size, emphasizing the need for further research in this area. However, this study provides preliminary evidence suggesting that there is value in integrating family in reminiscence-based social visits with PLwD through the use of technology.

The Distinct Role of OT in Utilizing Technology to Support Social Occupations for Persons Living with Dementia

Social Participation is one of nine broad occupations included in the Occupational Therapy Practice Framework (OTPF), a document that describes the scope of practice for occupational therapy (AOTA, 2020). The occupation of social participation includes all areas of interaction that support social interdependence including interactions with family, friends, peers and the community (AOTA, 2020).

In order to support social participation through a virtual platform, OTs must act as collaborative partners, educating and supporting family and friends who plan to visit PLwD (AOTA, 2020). Communication accessibility and psychosocial interactions have been identified as needs for PLwD living in SNFs (Siberski & Siberksi, 2018). With approximately 20% of OTs

and 56% of OTAs working in SNF settings (AOTA, 2015b), occupational therapy practitioners have the opportunity to play a critical role in facilitating engagement in social participation for PLwD and family members (Rafeedie et al., 2018). Family and caregiver education and training fall within the scope of practice for occupational therapy, qualifying OTs to effectively conduct dementia care training tailored specifically to the needs of PLwD and their families when engaging in virtual reminiscence (AOTA, 2020). Training family and friends of PLwD to utilize technology to facilitate meaningful communication through reminiscence can mitigate the consequences of isolation and sensory deprivation among PLwD.

As stated by Rafeedie et al. (2018), “evidence exists that the goals of occupational therapy directly link to QoL and positive effects on health and wellbeing. Specific areas in which occupational therapy interventions facilitate these positive outcomes include engaging in meaningful activities related to social and leisure participation” (Matuska et al., 2012, p.4, as cited in Rafeedie). OT practitioners are uniquely positioned to better meet the needs of residents in SNFs by expanding their scope of practice and addressing social occupations, specifically through the use of virtual mediums.

Telehealth within OT Practice in SNFs

Telehealth is a technology platform that allows OTs to deliver healthcare services to PLwD. The profession of OT encompasses a holistic lens and considers the social context of the PLwD including the caregiver, and family when providing client-centered care (Nissen & Serwe, 2018). Telehealth can be used as a support for caregivers. OTs understand that not only should the focus be on the PLwD, but the dementia-caregiver dyad which involves the PLwD and the family members. The family member within this dyad may experience burden from providing care and those living in rural areas may have difficulty receiving access to OT (Nissen & Serwe,

2018). As technology advances, OTs can utilize it to solve accessibility barriers and improve healthcare delivery to the dementia-caregiver dyad. Even as family members step back from the role of primary caregiver, and the staff at SNFs assume responsibility for the PLWDs day to day care, the social relationships with family caregivers are vital to maintain.

Utilizing technology to facilitate interactions with caregivers and family expands the environmental context for the PLWD beyond the walls of the SNF to allow family centered care to be available even when family is not present physically. Nissen & Serwe (2018) examined studies that used telehealth to deliver OT services and the effectiveness of the platform. In their review, positive outcomes resulted in relation to caregiver burden, managing dementia-related behaviors, and social support (Nissen & Serwe, 2018). Telehealth also provides an opportunity for PLWD to engage in social interactions which helps to reduce loneliness and increase QoL, as well as improving overall physical health and longevity (Walmsley & McCormack, 2017). Telehealth has the potential to be an effective method for OT service delivery focused on social occupations that will improve QoL for PLWD, caregivers, and family members.

Conclusion

Approximately two thirds of SNF residents have some form of cognitive impairment such as dementia (Gaugler, et.al, 2014). As dementia progresses, PLWD experience memory loss and significant impairments to their communication abilities (Laver, Clemson, Bennett, Lannin, & Brodaty, 2014). Decline in functional ability, impaired cognition, and neuropsychiatric symptoms are factors that may lead to institutionalization for PLWD in SNFs (Brodaty et. al, 2014). These impairments are often perceived by caregivers as a lack of agency and capability in the PLWD and can result in care practices that further isolate and decrease social opportunities, which may contribute to sensory deprivation in this population and thus a lower quality of life

(AOTA, 2017). COVID-19 visitation regulations as well as ongoing barriers of geographical distance present additional challenges when seeking to engage PLwD residing in SNFs in meaningful social occupations.

The utilization of reminiscence therapies (Moon & Park, 2020) and the increased participation of familiar family and friend relations (Walmsley & McCormack, 2017) are effective in mitigating the presence and impact of loneliness and sensory deprivation for PLwD who reside in SNFs, resulting in improved QoL. While reminiscence and familial interactions are effective tools to support social occupations for PLwD, Riachi (2018) notes that family and friends may find engagement with their loved one difficult due to dementia related communication deficits. While little research exists on effective intervention strategies that support social occupations for PLwD, Ouslander & Grabowski (2020) have looked to virtual visitation as a potential modality to enhance social engagement and minimize physical barriers to visitation for PLwD. The use of a virtual platform in conjunction with reminiscence therapies holds promise, as it allows for streamlined access to photos, music, storytelling, and face-to-face interactions. The facilitation of social occupations falls into the purview of occupational therapy. OTs are trained on the cognitive, physical, and social effects of dementia, and are in a unique position to promote engagement of social occupations among PLwD in SNFs, especially in the face of COVID-19 related visitation restrictions.

Statement of Purpose

The goal of the SFVR intervention is to promote socialization for PLwD in SNFs by introducing an evidence informed tool and educational resource for SNF-based OT practitioners. The virtual nature of the SFVR intervention provides an opportunity for OTs' to include social occupations in their treatment plans despite COVID-19-related visitation restrictions. Utilizing technology to provide access to socialization and virtual reminiscence has the potential to increase the QoL of PLwD in SNFs.

The OTPF-IV identifies nine major occupations within the scope of OT practice, including the occupation of social participation (AOTA, 2020). This, in conjunction with occupational therapists' unique understanding of the remaining abilities of PLwD, and their ability to modify and adapt tasks and environments, situates OTPs as the ideal clinicians to utilize the SFVR intervention.

To achieve this goal, a novel virtual reminiscence intervention and associated resources will be created, distributed, and piloted at a handful of Ensign-affiliated SNFs. The use of the SFVR intervention by Ensign-affiliated, SNF-based OTPs will not only empower the practitioners to elicit long-term memories that provide meaning, context and a point of engagement between the PLwD and their loved one; but will also to expand their use of the OT scope of practice by promoting social occupations for their clients.

Theoretical Framework

This project was guided by the Canadian Model of Client-Centered Enablement (CMCE) and the Cognitive Disabilities Model. These frameworks were chosen based on their emphasis on client enablement.

Figure 1 The Canadian Model of Client-Centered Enablement (Townsend & Polatajko, 2007).

The Canadian Model of Client-Centered Enablement (CMCE) is a model that focuses on the relationship between occupational therapists and their clients. In this case, the “client” refers to the PLwD/family member dyad. The client-occupational therapist relationship is represented in the model by two curved lines. This signifies the multifaceted, dynamic, participatory, collaborative and evolving nature of the professional relationship between OT and client (Townsend & Polatajko, 2007). The CMCE emphasizes effective enablement while also actively seeking to avoid missed opportunities to enable clients (Craik, 2010). Occupational therapists work to maximize the effective enablement of the client through use of the key skills of adapting, advocating, coaching, collaborating, designing/building, educating, engaging, and specializing

(Craik, 2010). This model of enablement differs from the more traditional “rehabilitative” approach that focuses on therapeutic exercise and activity often used in SNFs. In the CMCE, the OT moves beyond a direct service provider to play a role in advocacy, consultation and collaboration often at an organizational level (Rafeedie et al., 2021; Townsend & Polatajko, 2007).

The significance of these terms as related to our project are listed in the table below.

Table 1 Key Skills of Enablement

Key Skills	Definition
<i>Adaptation</i>	Provide a “just right” challenge for clients that matches the demand of the task with the abilities of the client (Townsend & Polatajko, 2007).
<i>Advocacy</i>	Act as a change agent, raising awareness about issues others may miss and challenging people to think differently (Townsend & Polatajko, 2007).
<i>Collaboration</i>	Work with clients and caregivers to create a shared power dynamic that is altruistic and based on trust (Townsend & Polatajko, 2007).
<i>Consultation</i>	Exchange views and confer in positions that focus on developing and designing programs at a community, organization, or population level as opposed to a more traditional direct service model.
<i>Designing / Building</i>	Create programs and modifications to physical and emotional environments (Townsend & Polatajko, 2007).
<i>Engagement</i>	Encourage clients to participate in meaningful occupations and conversations (Townsend & Polatajko, 2007).

The Cognitive Disabilities Model (CDM), developed by Claudia Allen, does not view cognitive remediation as a reasonable goal for individuals with serious degenerative cognitive

impairments (Brown, Stoffel, & Munoz, 2019). Instead, the model provides a framework for occupational therapists to create situations that support the individual at their level of cognitive ability (Brown, Stoffel, & Munoz, 2019). Occupational therapists practicing under this model, assess PLwD using the Allen Cognitive Battery in order to determine their level of cognitive functioning and to identify their remaining abilities. Interventions based on the CDM are designed to promote a fit between a PLwD's remaining abilities and the activity demands of what is cognitively realistic (Can Do), personally relevant (Will Do) and socially and environmentally possible (May Do) (McCraith, et al., 2011).

The SFVR project has been developed to work in alignment with the Cognitive Disabilities Model. OTs working at Ensign affiliated SNFs are trained to evaluate residents and to determine the residents cognitive abilities based on their performance on assessments in the Allen Cognitive Battery. The SFVR intervention is designed for residents who are functioning at ACL levels 3 (middle stage) and 4 (early stage). This allows the therapist to determine if the SFVR is an appropriate cognitive fit for the resident. Additionally, the SFVR intervention carefully considers “can do,” “will do” and “may do” factors by addressing each of these factors within the training module. “Can Do” factors relate to what the individual is cognitively, physically, and emotionally able to accomplish. “Will Do” factors relate to the meaningful and relevant activities in which the individual wants to participate, directed by his or her values or culture. “May Do” factors reflect what is possible within the environment and include the family as part of the PLwD's context (Brown, Stoffel, & Munoz, 2019).

Ethical and Legal Considerations

The Occupational Therapy Code of Ethics (the Code) of the American Occupational Therapy Association (AOTA, 2015) served as a resource for ethical decision-making and legal

considerations in the development and implementation of this project. The Code principles pertaining to this project include Beneficence and Fidelity. Beneficence applies to personnel demonstrating a concern for the well-being and safety of the clients receiving services (AOTA, 2015). To abide by this value, OTs at Ensign-affiliated facilities completed a training program in order to implement the SFVR program, designed to improve the QoL of PLwD through the promotion of social occupations. The second highlighted Code principle related to this project is Fidelity. This principle states that personnel shall preserve, respect, and safeguard private information (AOTA, 2015). In line with the value of Fidelity, training materials for SNF OTs emphasized the need for participant information to be kept confidential, and included consent forms as well as protocols about maintaining privacy of reminiscence materials. Surveys, interviews or notes collected by the project designers related to outcome measures after project implementation were kept confidential, as well. This project abided by all legal policies, procedures, and protocols serving the participants at Ensign Affiliated SNFs. All visitation protocols will be HIPPA compliant.

Methodology

Project Design

The SFVR was designed using a strengths-based approach in alignment with the Cognitive Disabilities Model. The intervention provides guidelines for individualized dementia care related to engagement in reminiscence-based social occupations. The SFVR intervention utilizes a visitation template, formatted within a Microsoft PowerPoint, that can be populated with pictures, music, and videos, in order to elicit long-term memories that provide meaning, context and a point of engagement between the PLwD and their loved one. The visitation template includes topics that align with the Occupational Therapy Practice Framework IV's occupational domains of Social Participation with emphasis on family and friends, work and education, and leisure with focus on interests and hobbies (AOTA, 2020).

To further enhance the efficacy of the SFVR intervention, the reminiscence template carefully considers what the resident living with dementia “Can Do,” “Will Do,” and “May Do” as part of the skilled services OTs contribute. Understanding the cognitive level of the resident and what they “Can Do” is important as the reminiscence materials are selected in alignment with the resident's cognitive level and retained abilities. Implementation of the SFVR interventions relies heavily on the OTs knowledge of environmental modification, appropriate cueing, and stage-specific remaining abilities of the resident to ensure proper facilitation. The template incorporates “Will Do” factors by considering the residents' sensory preferences, as well as through the incorporation of their specific interests, habits, and roles. Within the context of “May Do,” OTs collaborate with the family members of the PLwD to create the individualized reminiscence template, and then use the aforementioned template as a tool to facilitate the visit between the PLwD and their family member. In order to support the resident in this phase of the

intervention, the OT will consider any necessary environmental modifications and facilitate family training on communication techniques specific to PLwD.

The SFVR intervention includes a web-based training module for SNF OT practitioners on intervention utilization, all supporting documents (email templates, waivers, and family informational handouts), and the visitation template used during the intervention. The SFVR training module, designed for SNF OTs, provides a dementia-informed best practice training, information on which residents are appropriate for the program, guidance on documentation and billing for the SFVR, and a guide on how to construct the visitation template with the family member or friend. After completing the training module, the OT will be equipped to facilitate a virtual visit between the PLwD and their family member using the provided visitation template.

In order to maximize learner engagement, this training module was created with RiseArticulate software, and utilizes multimodal teaching strategies including readings, videos, audio clips, and interactive learning activities. Research by Blom, Zarit, Groot, Zwaafink, & Cijpers (2015) indicates that a learner's active involvement in training may produce the most ideal learning outcomes. As such, active training sessions involving use of this online software will be an effective way to instruct OTs in conducting personalized reminiscence activities with PLwD, as opposed to passive deliverance of the same information through a pamphlet or handout.

Agency Description

This project has been created and piloted in collaboration with Ensign Services, an organization that supports operations and healthcare staff at over 250 Ensign-affiliated SNFs in 13 states. Through the use of informal interviews, needs assessments, and ongoing collaboration

with an Ensign interdisciplinary team, areas of challenge were identified within the current practice and opportunities for the enhancement of social occupations for PLwD were explored.

Ensign leadership and facility stakeholders have worked with Dominican student developers by providing feedback and guidance on feasibility during project development. Collaborating stakeholders at Ensign included a leader from the long-term care committee and a lead trainer for the Abilities Care Approach (ACA). These two individuals served as the primary contacts for the duration of the project.

The ACA is a stage-specific, person-centered, strengths-based approach that promotes the remaining abilities of the PLwD and is rooted in the Cognitive Disabilities Model. The SFVR has been specifically designed to complement this approach as it guides the practice of many Ensign-affiliated OT practitioners.

Target Population

The target population of this project is Ensign-affiliated occupational therapy practitioners working with residents experiencing early and middle stage dementia. Ensign-affiliated facilities that use the ACA also utilize the Allen Cognitive Levels to determine dementia severity and identify remaining abilities among their residents. Ensign-affiliated OT practitioners will implement this intervention for residents who are specifically experiencing early or middle stage dementia, or ACL levels 3.0 - 4.8. Participating residents were also required to have at least one friend/family member who was willing and able to engage in a virtual visit with the PLwD using the SFVR program.

Project Development

The Supported Family Visits through Reminiscence (SFVR) intervention was developed through a review of existing literature, as well as through the findings of the needs assessment

conducted among therapy practitioners who work in Ensign-affiliated SNFs. These results informed the design of the Supported Family Visit through Reminiscence intervention. Additionally, this project was created in response to regulations restricting visitation to SNFs due to the COVID-19 pandemic (CMS, 2020). As restrictions were put in place across the country, the impact on social occupations for PLwD became a topic of interest and concern. This project was made possible through the guidance provided by Dominican University of California faculty member Dr. Gina Tucker-Roghi and the support of Ensign-affiliated rehabilitation team members.

Project development occurred in two main stages. First, gaps in OT practice regarding the promotion of social occupations were identified in a thorough literature review. With these findings, a needs assessment (see Appendix A) was created and distributed to therapy practitioners at Ensign-affiliated SNFs related to their promotion (or lack thereof) of social occupations with residents. The initial needs assessment survey was given to participating therapists in order to evaluate the following: if they consider social occupations when developing intervention plans; what interventions, if any, they use to support social occupations; and if there are barriers preventing their use of social occupation interventions. The results from the survey indicated that therapists consider social occupations when designing interventions and are able to incorporate some interventions that support social occupations. Therapists highlighted specific barriers to incorporating social occupations in their interventions including the following: documentation, interventions that are deemed billable, resistance from patients due to cognitive impairment, time constraints, support from facility, and COVID constraints. The results from this survey informed the direction we chose to take in developing our intervention. To supplement the largely quantitative data identified in the needs assessment, multiple Zoom conferences were

held with the aforementioned multi-disciplinary team of Ensign OTs, PTs, and SLPs in order to obtain qualitative information about the needs of the setting.

The second main step was to develop the intervention, which included identification of the target audience, determination of the scope and purpose of the project, as well as discernment regarding the content and mode of delivery of the training module. Student project developers learned to navigate and utilize the software, Rise Articulate, in order to create such modules. Communication with the administration and the legal department at Ensign (occurring via email) was essential to ensure legal and HIPAA compliance in the creation of the intervention module. Once the SFVR module and materials are approved for use, the intervention will be disseminated to Ensign-affiliated therapists.

Project Implementation

Project implementation will begin in June 2021 and run through October 2021. Materials will be presented to OTs and rehabilitation therapists working at Ensign-affiliated SNFs. These OT practitioners will be invited to a training event hosted for Therapy Experts for the Abilities Care Holistic Approach (TEACHAs) who are field educators and leaders for the Abilities Care Approach. During the Spring 2021 TEACHA 2.0 event, Ensign therapy practitioners will learn how to utilize the SFVR program with residents with dementia and their family members. After completing the training, Ensign partners will be responsible for recruiting PLwD, and sharing training materials with other OT staff in their geographic regions. The training modules, supporting documents, template instructions, and template will be uploaded and available for use in the Ensign Learning Management System. A second web-based training event in Fall 2021, the Long-Term Care Think Tank, will be hosted by the Ensign Long Term Care Committee for therapists working in Ensign-affiliated SNFs.

Seed grant funding in the amount of \$250 was awarded from the California Foundation for Occupational Therapy. These funds will be used to create (design, print, laminate, etc.) deliverables for the project, as well as to purchase Starbucks gift cards as incentives for those who completed post-intervention surveys.

Project Evaluation Plan

Participating Ensign OTs will complete semi-structured interviews and surveys to assess SFVR efficacy, feasibility, and project outcomes.

Two post-training surveys meant to measure the quality of the presentations and associated therapist interest in implementing the SFVR intervention, will be distributed following practitioner participation in the TEACHA 2.0 (see Appendix B), and Long-Term Think Tank training events (see Appendix C).

A summative survey will be distributed following the OT's completion of the RiseArticulate course to determine efficacy and impact specifically of the training module (see Appendix D).

Three months post training, interviews will be completed with therapists who have completed the Rise Articulate Training Module (See Appendix E).

SFVR materials will be housed in the Ensign LMS and available for use by Ensign facility staff. As such, continuous evaluation of the RiseArticulate training and SFVR intervention will occur with the use of the provided surveys.

Conclusion

The aim of this project is to expand the scope of SNF-based OT practice and provide support and resources for OT practitioners to facilitate virtual reminiscence-based social visits for PLwD and their loved ones when an in-person visit is not possible. The SFVR intervention aims to promote social engagement which transcends physical barriers and visitation restrictions, and has the potential to dramatically impact QoL of PLwD in SNFs at this time. The SFVR intervention is designed to engage the remaining abilities of PLwD to enhance the quality of visits. The OTPF identifies nine major occupations including social participation in the scope of practice for occupational therapists (AOTA, 2020). Occupational therapists have a unique understanding of the remaining abilities of PLwD and are ideally situated in SNFs to provide the SFVR skilled intervention.

The intended outcome of this project is to create an intervention that facilitates the social occupations of SNF residents living with dementia. In order to accomplish this outcome, a novel intervention program and all required materials were created, disseminated, and will be implemented at an Ensign-affiliated facility. The implementation and use of the SFVR intervention by Ensign-affiliated OT practitioners offers an opportunity to increase the QoL for PLwD and empower SNF OTs to expand their use of the OT scope of practice to address and promote social occupations among people living with dementia.

Section II
Manuscript

Introduction

In March 2020, governments across the world introduced visitor bans throughout skilled nursing facilities (SNFs) in response to the COVID-19 pandemic, curtailing visitation access for families, friends, and volunteers. PLwD (people living with dementia) have been disproportionately impacted by these restrictions as, within the United States, these individuals are four times more likely to receive care in a SNF as compared to someone without a cognitive impairment (Borda et al., 2020). With such a large number of PLwD residing in SNFs, it is vital that dementia care best practices are woven into occupational therapy (OT) treatment in this setting. PLwD in SNFs are likely to experience distress related to the absence of relatives who would normally visit them (Numbers & Brodaty, 2021) and the impact of these visitation restrictions has been significant. The resulting social isolation among PLwD in SNFs has led to an increase in psychiatric symptoms such as stress, anxiety and depression (Numbers & Brodaty, 2021). While COVID-19 has highlighted the importance of consistent familial social interaction for PLwD, this is not a new phenomenon.

Within the SNF, OT treatment is overwhelmingly made up of activities coded as “therapeutic exercise,” which was billed under OT services 9,594,480 times between 2014 and 2016 (Centers for Medicare and Medicaid Services [CMS], 2016). In a pilot study conducted by Jewell et al. (2016), it was determined that 50% of the time, occupational therapy practitioners (OTPs) working in SNFs were engaging their clients in “exercise or rote practice” interventions, as opposed to interventions that are occupation based, centered, or focused. Under-utilization of social occupation-based treatments is the result of many complex factors. Ragsdale & McDougall (2008) assert, “in traditional long-term care settings, QoL interventions that address dignity, freedom of choice, and individuality are not always a priority” (p. 992). Instead, a

prioritization of safety concerns is often seen throughout contemporary practice. An over-reliance on therapeutic exercise and therapeutic activities in the interest of residents' safety curtails the OTP's utilization of poignant occupation-based interventions, which have the power to influence both the client's health and QoL.

With 20% of OTs and 55% of occupational therapy assistants (OTAs) employed in SNFs (American Occupational Therapy Association [AOTA], 2015), OTPs are poised to address the development and utilization of dementia care best practices within their facilities, including those addressing social occupations. If equipped with the knowledge, tools, and agency with which to support PLwD in meaningful social engagement, OTPs can utilize their full scope of practice to combat the impact of social isolation upon the QoL for PLwD. To aid practitioners in this effort, our Dominican University of California capstone team created and piloted the Supported Family Visit through Reminiscence (SFVR) Intervention and associated training module for SNF OTPs. The SFVR intervention allows SNF OTPs to facilitate virtual visits between residents with dementia and their loved one through use of a reminiscence-based visitation tool. Individualized reminiscence therapy is an effective intervention to support social interactions and enhance QoL for PLwD (Day, Gould, & Hazelby, 2020).

The SFVR Intervention

Globally, the use of technology has been of paramount importance since the COVID-19 crisis arose in 2020, and the continued use of these technologies to enhance OT practice is worth consideration. Telehealth can function as an effective form of service delivery for evidence-based interventions (Ouslander and Grabowski, 2020) and serve as an access point for PLwD to engage in social opportunities that will reduce loneliness, increase QoL, and improve overall physical health and longevity (Walmsley & McCormack, 2017). The SFVR intervention utilizes

this telehealth approach in order to deliver an evidence-based tool grounded in reminiscence therapy (RT), the process of recalling personal events or experiences that are memorable to the individual, allowing them to rely on more easily accessible long-term memories (Dempsey et al., 2014). This non-pharmacological solution to addressing social occupations has the potential to mitigate the effects of isolation and sensory deprivation among PLwD, making this approach one of the most popular psychosocial interventions in dementia care (Lohda & De Sousa, 2019). Qualitative research regarding social visits between PLwD and their spouses found that using reminiscence materials helped to facilitate communication, provide connection through remembering past experiences, and alleviate the stress of disconnection during visit (Dassa, 2018).

Facilitation of the SFVR intervention relies heavily on engagement from the resident's family and friends. As education and training are essential aspects of OT practice, OTPs have the skills to effectively guide family and friends of PLwD to engage in reminiscence-based social interactions. In order to support virtual social occupations for PLwD in SNFs, OTPs will work collaboratively with family and friends who plan to visit residents with dementia (AOTA, 2020). OTP and visitor collaboration is crucial for successful facilitation of meaningful interactions as PLwD require support with communication accessibility and for their specific psychosocial needs to be addressed (Siberski & Siberksi, 2018). As part of the SFVR intervention, OTPs will offer support by modifying the environment to optimize engagement and participation within the virtual platform, educating family and friends on specific communication strategies, and supporting the psychosocial needs of PLwD by identifying reminiscence topics that are meaningful to PLwD and support lifelong roles and interests. The SFVR provides OTPs with the resources and training to provide these services and thus implement this novel

intervention. The SFVR intervention utilizes a *visitation template* which can be populated with pictures, music, and videos in order to elicit long-term memories that provide meaning, context, and a point of engagement between the PLwD and their loved one. Following participation in the SFVR web-based training module, the OTP will schedule a virtual visit with the family member or friend of the PLwD and then collaboratively populate the template as a group, taking notice of which topics are most engaging to the resident and elicit the greatest verbal and nonverbal feedback. To help guide the visit, the visitation template includes topics that align with the Occupational Therapy Practice Framework IV (AOTA, 2020) and support reminiscence through the use of the individual's roles, interest, and meaningful occupations. Specifically, the template includes slides for: About Me, Family and Friends, Work and Education, and Interests and Leisure.

Figure 2 SFVR Visitation Template Sample for Topic 1: Family & Friends

The SFVR relies on the OTP's knowledge and skills for environmental modifications, caregiver education on adaptive communication strategies, appropriate cueing, and the facilitation of the residents primary remaining abilities. A web-based training module and associated print resources are available to support and expand the OTPs knowledge and skills regarding dementia care, and to educate OTPs working in SNFs on how to best incorporate RT into their practice. The training consists of twelve modules that address dementia care best

practices for OT practitioners, instruction on how to implement the SFVR intervention, and guidance related to documentation and billing. Within the training modules, OTPs can access all supporting materials required for implementation of the intervention, including a consent form, family participation guide and instructions, and the virtual visitation template to be used during the intervention.

Figure 3 SFVR Visitation Guide

Piloting the SFVR Intervention: Findings

The SFVR intervention was piloted through the use of two separate live online presentations, during which the training module and associated resources were introduced to 34 practitioners from some of the 200+ Ensign-affiliated SNFs around the country. Following these sessions, the training and associated resources were made available to participants online.

In total, 13 practitioners completed the SFVR training module. While their engagement holds promise, additional support may be needed to facilitate a more widespread implementation of the SFVR. Responses indicated that the course was easy to follow, the content was comprehensive, and the SFVR had the potential to improve social interactions between PLwD and their visitors. The responses also indicated that technology may be a barrier to use due to the

limited technological knowledge of visitor's family members. Overall, the interviewees found the intervention to be both feasible and valuable, however, introducing a novel intervention and promoting culture change in SNFs during the COVID-19 pandemic presented unique challenges. SNF-staff's prioritization of resident safety, especially in the face of COVID-19 complications, may have limited their capacity to adopt new interventions. Additionally, the Dominican University of California capstone team existed outside of the pilot organization, and thus struggled to highlight successes or continuously nurture growth of the program. Looking ahead, an examination of implementation science may be useful for OTPs who aim to introduce novel interventions to expand the scope of practice in their own setting.

Championing Culture Change in the SNF Setting

The goal of the SFVR intervention was to promote socialization for PLwD in SNFs by introducing an evidence informed tool and educational resource for SNF-based OT practitioners. There was modest adoption of the novel intervention. Adoption of a new practice paradigm, in this case, one that prioritizes social occupations, is challenging, and understanding how to expedite the process of getting valid, evidence-informed tools into the hands of active practitioners is crucial. To this end, Juckett, Robinson, and Wengerd (2019) discuss five implementation strategies outlined by Powell et al. (2015). These strategies include assessing the group and/or practitioner's readiness to implement EBP; inclusion of the group or practitioner in the decision-making process to determine if the EBP is a good fit; development of a formal implementation plan; identification and inclusion of early adopters; and finally, identifying how the EBP can be adapted to fit the specific needs of the organization.

Though the SFVR intervention did not "take off" as intended following the piloting process, practitioners' feedback indicated that the intervention was usable, feasible, and

important. By expanding their scope of practice within SNFs, OTPs have the potential to participate in the remodeling of the culture to one that focuses on meaningful interactions, including those that address social occupations (Rafeedie et al., 2018). Such culture change can be made possible through OTPs' creation of evidence-informed tools and interventions within their own organization to promote the expansion of occupational therapy practice. The development and pilot implementation of the SFVR intervention was a small step in this effort, however there is still much work to be done.

Conclusion

As we pull back to take in the entire view of OT practice within the SNF setting, we see an environment in which OTPs, through various forces, are limited in how they provide treatment for their clients. Whether it be through contextual barriers, over emphasis on rehabilitative approaches, productivity standards, or even a lack of knowledge on dementia best care practices, it is clear that OTPs in SNFs can benefit from more support in achieving the holistic, occupation based, and necessary interventions they aspire to. To address this issue, OTPs can create their own evidence-informed interventions to address client-specific needs of the residents they treat. OTPs would further benefit from tools and training developed to support this change in practice, which ought to be created with consideration of effective implementation strategies.

Figure 4 SFVR Visitation Template for About Me and the Three Topics

The SFVR Intervention

- Includes a visitation template to be populated with pictures, music, and videos to promote shared connection and reminiscence between a PLWD and their loved one.
- About Me and 3 Topics:
  - Family and Friends
  - Work and Education
  - Interests and Leisure
- Training Module addressing:
  - How to complete the intervention
  - Communication tips for PLWD
  - Documentation and billing
  - Includes all documents to complete the intervention.

About Me

This section will include any information that can orient other staff members to who the resident is and main areas of interest that can facilitate effective communication.

Work and Education

This section will include information about the resident's past schooling, major jobs or professions, education opportunities, etc.

- Photos or videos of the resident's school or work
- Uniforms or clothing worn
- Awards or honors earned by the resident

Family and Friends

This section includes information about the resident's family, friends, and loved ones.

- Photos or home videos of the resident's family and friends
- A video message from a grandchild, sibling, etc.
- A photo or video with a group of the resident's childhood home

Interests and Leisure

This section includes the resident's favorite hobbies, interests, places, travel, vacations, books, music, movies, sports, religion, politics, art.

- Examples include photos or videos of the resident engaged in their hobby.
- Souvenirs or artifacts from trips, awards, ticket stubs

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Appendix A

Initial Needs Assessment

What is your position? Check all that apply.

3 responses

Do you implement interventions to support social occupations when working with a client with mild cognitive impairment and/or early stage dementia?

5 responses

Tell us a bit about the interventions you implement to support your clients' social occupations, if any.

5 responses

Encouragement to leisure activities.

Find out from them or their families what their career, hobbies, etc were and try to build that into treatment

Preferences identified at eval, and POC adjusted to accommodate

Identify the patients area of interest and we created 'jobs' for them. help with w/c repairs. help with being a receptionist at the front desk.

Do you have access to Zoom, or another virtual platform, at your facility to facilitate social interactions?

5 responses

Which platform would work best for your facility?

5 responses

Do you consider social participation when working with a client with mild cognitive impairment and/or early stage dementia?

5 responses

Which platform would work best for your facility?

5 responses

What are some barriers, environmental or personal, that you experience in implementing interventions to support social occupations?

5 responses

Time constraints, support from facility, COVID. Constraints

None

advanced dementia may impact opportunities for social interventions

resistance from patient due to advanced cognitive impairment

Please check any of the following barriers that apply to documenting interventions that support social occupations. Mark all that apply.

5 responses

Appendix B

TEACHA 2.0 Post Training Survey

TEACHA 2.0 Post Presentation Survey

Please complete the survey below following your completion of the *SFVR RiseArticulate module* as well as your participation in the *TEACHA 2.0 SFVR Presentation*. Your responses will be used to enhance the clarity and efficacy of the SFVR training materials for future OT practitioners.

On a scale of 1-5, rank your level of agreement with the statements below. Circle one response using the following scale: *1 – Strongly Disagree, 2 – Disagree, 3 – Neutral, 4 – Agree, 5 – Strongly Agree.*

After completing this course...

I am more confident in my ability to provide impactful therapy interventions that support the social occupations of individuals with dementia.

1. Strongly Disagree   2. Disagree   3. Neutral   4. Agree   5. Strongly Agree

I feel more confident in my ability to facilitate virtual visits for residents living with dementia and their loved ones.

1. Strongly Disagree   2. Disagree   3. Neutral   4. Agree   5. Strongly Agree

I understand how to modify and set up the environment for residents living with dementia to promote their remaining abilities.

1. Strongly Disagree   2. Disagree   3. Neutral   4. Agree   5. Strongly Agree

I will address social occupations in my future treatment sessions.

1. Strongly Disagree   2. Disagree   3. Neutral   4. Agree   5. Strongly Agree

Following this presentation...

I will utilize the SFVR intervention in my future treatment plans.

1. Strongly Disagree   2. Disagree   3. Neutral   4. Agree   5. Strongly Agree

Overall...

The content presented in the online module supported my learning needs.

1. Strongly Disagree   2. Disagree   3. Neutral   4. Agree   5. Strongly Agree

Evidence was provided to substantiate the material presented.

1. Strongly Disagree   2. Disagree   3. Neutral   4. Agree   5. Strongly Agree

What barriers do you anticipate in implementing an online visitation intervention?

Please provide any additional comments or thoughts you have regarding the SFVR intervention.

Overall, how would you rate this course?

1. Poor   2. Fair   3. Good   4. Very Good   5. Excellent

Appendix C

Long Term Think Tank Post Training Survey

Ensign Think Tank Follow Up Survey

Your feedback will help us make this project great! Thank you for your time and support.

* Required

1. Email *

2. Following this presentation, I feel motivated to provide therapy interventions that support the social occupations of individuals with dementia.

Mark only one oval.

☐ Strongly disagree

☐ Disagree

☐ Neutral

☐ Agree

☐ Strongly agree

3. Following this presentation, I feel more confident in my ability to facilitate virtual visits for residents living with dementia and their loved one.

Mark only one oval.

☐ Strongly disagree

☐ Disagree

☐ Neutral

☐ Agree

☐ Strongly agree

4. Following this presentation, I'm definitely going to address social occupations in my future treatment sessions.

Mark only one oval.

☐ Strongly disagree

☐ Disagree

☐ Neutral

☐ Agree

☐ Strongly agree

5. Following this presentation, I'm definitely going to utilize the SFVR intervention in my future treatment plans.

Mark only one oval.

☐ Yes

☐ No

☐ Possibly

6. What barriers do you anticipate in implementing an online visitation intervention?

7. Please provide any additional comments or thoughts you have regarding the SFVR intervention.

Appendix D

Rise Articulate Post Training Survey Analysis

Course Evaluation Survey Analysis

9/11/2021

Hierarchies	All
Course	Social Occupations for Residents with Dementia: Supported Family Visits through Reminiscence (SFVR)
Training Plan	All
New Hire Compliance Year	All
User Locations	All
Job Titles	All
Employment Types	All
User Categories	All
Learner Status	Active
Date Range	9/11/2020 - 9/11/2021
Business Line	All
State	All
Group Name	All
Hire Date Range	-
Evaluation Template	

1. After completing this course, I am more confident in my ability to provide impactful therapy interventions that support the social occupations of individuals with dementia.	#Responses	Percentage
Strongly Disagree	2	40.00%
Disagree	0	0.00%
Neutral	0	0.00%
Agree	1	20.00%
Strongly Agree	2	40.00%
Total Responses	5	

2. After completing this course, I feel more confident in my ability to facilitate virtual visits for residents with dementia and their loved ones.	#Responses	Percentage
Strongly Disagree	2	40.00%
Disagree	0	0.00%
Neutral	0	0.00%
Agree	1	20.00%
Strongly Agree	2	40.00%
Total Responses	5	

3. After completing this course, I understand how to modify and set up the environment for residents living with dementia to promote their remaining abilities during virtual family visits.	#Responses	Percentage
Strongly Disagree	2	40.00%
Disagree	0	0.00%
Neutral	0	0.00%
Agree	0	0.00%
Strongly Agree	3	60.00%
Total Responses	5	

Course Evaluation Survey Analysis

9/11/2021

4. After completing this course, I will address social occupations in my future treatment sessions.	#Responses	Percentage
Strongly Disagree	2	40.00%
Disagree	0	0.00%
Neutral	0	0.00%
Agree	1	20.00%
Strongly Agree	2	40.00%
Total Responses	5	

5. Following this presentation, I will utilize the SFVR intervention in my future treatment sessions to address social occupations.	#Responses	Percentage
Strongly Disagree	2	40.00%
Disagree	0	0.00%
Neutral	0	0.00%
Agree	1	20.00%
Strongly Agree	2	40.00%
Total Responses	5	

6. Overall, the content presented in the online module supported my learning needs.	#Responses	Percentage
Strongly Disagree	2	40.00%
Disagree	0	0.00%
Neutral	0	0.00%
Agree	1	20.00%
Strongly Agree	2	40.00%
Total Responses	5	

7. Overall, evidence was provided to substantiate the material presented.	#Responses	Percentage
Strongly Disagree	2	40.00%
Disagree	0	0.00%
Neutral	0	0.00%
Agree	0	0.00%
Strongly Agree	3	60.00%
Total Responses	5	

8. Overall, how would you rate this course?	#Responses	Percentage
Excellent	4	80.00%
Very Good	1	20.00%
Good	0	0.00%
Fair	0	0.00%
Poor	0	0.00%
Total Responses	5	

9. What barriers do you anticipate in implementing an online visitation intervention?	#Responses	Percentage
	4	80.00%
How to implement SFVR c residents who have poor hearing AND vision.	1	20.00%
Total Responses	5	

10. Please provide any additional comments or thoughts you have regarding the SFVR intervention.	#Responses	Percentage
	4	80.00%
none	1	20.00%
Total Responses	5	

Appendix E

Post Rise Articulate Training Follow-up Interview Questions/Responses

Interview Questions	Interviewee #1	Interviewee #2
Was the Rise Articulate training helpful?	Yes, I completed the training. Beautifully done, kudos. Succinct, which is great. Manageable based on time constraints. Information is condensed, clearly communicated, expectations	“I thought it was great, could reach caregivers and others not trained” Really captures the importance of dementia Reasonable amount of time, easily implemented
What was least helpful/challenging about the Rise Articulate training?	Was difficult to find the training in Ensign Learning Management System, QR codes helped a lot Dementia training was helpful, especially for those who do not specialize in dementia care. Transition to telehealth and learning new technologies was difficult.	Technology is a challenge, but gets easier the more you do it.
Have you implemented the SFVR intervention?	Not firsthand, but have spoken with practitioners that have.	Not firsthand, but have received feedback from those who have.
What went well when implementing the SFVR intervention?	Helped provide direction for social interactions. Improved content of the interaction, more meaningful dialogue Training addresses billable time and documentation for reimbursement, that is helpful	Aligns with Life History Profile (a preexisting intervention at Ensign facilities)
What aspects of the SFVR intervention need improvement?	Using technology was the most difficult part for the visiting family member.	Not appropriate for ACL levels below 3.

How confident are you in your ability to provide impactful therapy interventions that support social occupations of individuals with dementia?	Feels confident, but didn't see the need for it until COVID changed regulations. Was a hole that was always there, though.	Very, I've been working with this population for 10 years. That's why I'm excited about this project, it's basically what we already do, but now it's virtual.
Has this changed after completing the Rise Articulate training and implementing the SFVR intervention?	Caseload growth. More therapists are needed in long term care settings and the need for this type of intervention is urgent.	No, but I think this is a tool that will make it easier for OTs that are unfamiliar with working with residents with dementia.
Can you please share with us your experience with collecting and embedding materials into the SFVR template?	Technology is a barrier to feasibility. Hard copies would be helpful.	I didn't do that part, but it's low tech, so more people can use it.
Is there any other information you would like to share with us?	Overall, has people thinking differently about engagement in social occupations.	This will definitely get buy-in from SNF staff!

Appendix F

QR code to access Rise Articulate Training Module