LUNDS UNIVERSITET
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Institutionen för hälsovetenskaper
Arbetsterapeutprogrammet

# Swedish occupational therapists' views and experiences regarding use of the ADL-taxonomy in clinical practice

## -A qualitative interview study

Author: Claire Hu

Supervisor: Marianne Kylberg

Bachelor thesis, An interview study

Spring 2023

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## Abstract

**Background:** The ADL-taxonomy as an assessment instrument shows high validity and reliability in the clinical research, but there is no study about occupational therapists' experiences of using the ADL-taxonomy in clinical practice. It is important to study the users' experiences and views to improve implementation of evidence-based methods such as the ADL-taxonomy.
**Aim:** The aim of this study is to explore Swedish occupational therapists' views and experiences regarding use of the ADL-taxonomy as an assessment instrument in clinical practice.
**Method:** Qualitative design with semi-structured interviews was used. Inductive content analysis was used to analyze the collected data with five licensed Swedish occupational therapists .
**Results:** The analysis resulted in two main categories: (1) Trying to be professional and (2) Depending on the environmental impact. The occupational therapists considered use of the ADL-taxonomy to be a positive aspect in professional development, however their performances were strongly affected by the enviormental factors in clinical practice.
**Conclusion:** Using evidence-based assessment methods such as the ADL-taxonomy is important for Swedish occupational therapists' professional development. However, whether to choose the ADL-taxonomy and how to use it depend on the specific patient and the environmental factors. To encourage the implementation of evidence-based methods in clinical practice, healthcare organizations need to make an effort to build supportive work environments for practitioners.
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## Keywords

Activities of daily living (ADL), assessment of ADL, environmental factors, professional development, standardized instrument, work environment.

# Svenska arbetsterapeuters syn på och upplevelser av användningen av ADL-taxonomin i det kliniska arbetet

## - En kvalitativ intervjustudie

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Examensarbete på kandidatnivå, Intervjuestudie
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## Abstrakt

**Bakgrund:** Enligt klinisk forskning visar ADL.taxonomin hög validitet och reliabilitet, men det finns inga studier kring svenska arbetsterapeuters erfarenheter av att använda ADL-taxonomin som bedömningsinstrument i sitt kliniska arbete. Det är viktigt att studera användarnas erfarenheter och synpunkter för att förbättra implementering av evidensbaserade metoder såsom ADL-taxonomin.
**Syfte:** Syftet med studien var att undersöka svenska arbetsterapeuters syn på och upplevelser av attanvända av ADL-taxonomin som ett bedömningsinstrument i sitt kliniska arbete.
**Metod:** Studien har en kvalitativ design. Semistrukturerade intervjuer genomfördes med fem legitimerade arbetsterapeuter verksamma inom olika verksamheter. En induktiv innehållsanalys användes för att analysera insamlad data.
**Resultat:** Analysen resulterade i följande två huvudkatergorier (1) Försöker vara professionell och (2) Blir påverkad av olika omgivningsfaktorer. Arbetsterapeuterna ansåg att användningen av ADL-taxonomin är en positiv aspekt av deras professionella utveckling, samtidigt som omgivningsfaktorer i deras arbetsmiljö spelade en viktig roll för dem i klinisk praxis.
**Slutsats:** Användningen av evidens baserade bedömningsmetoder såsom ADL-taxonomin är viktigt för arbetsterapeuters professionella utveckling men påverkas av olika omgivningsfaktorer i klinisk praxis. Om ADL-taxonomin ska väljas och hur den ska användas beror dock på den specifika patienten och miljöfaktorerna. För att uppmuntra implementering av evidensbaserad metoder i klinisk praxis måste vårdorganisationer anstränga sig för att skapa stödjande förutsättningar i arbetsmiljö för personalen.

## Nyckelord:

Aktiviteter i det dagliga livet (ADL), arbetsmiljö, bedömning av ADL, omgivningsfaktorer, professionell utveckling, standardiserat instrument.

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# Content

# Introduction

Choosing the right instrument in an assessment is important for occupational therapists in their clinical practices. The instrument should contain the facts that they want to investigate and be sensitive to what they want to assess (Law et al., 2005). To suit the clinical practice, the instrument needs to be easy to administer, easy to document, and ethically defensible (Wade, 2002). Scientific researchers and authorities usually recommend standardized instruments in clinical practice. According to Bejerholm and Hultqvist (2020), every occupational therapist 's clinical practice should be based on evidence-based methods. Using a standardized instrument to evaluate a client's activity situation is one typical evidence-based method. Standardized instruments help practitioners to obtain relevant information through systematically asking questions and provide equal assessments to different patients no matter time and location (Socialstyrelsen, 2012). However, in certain practice contexts routine use of standardized instruments is found to be challenging for clinicians (Strauss et al., 2013).

The Activities of Daily Living (ADL) Taxonomy – an assessment of activity ability, as a standardized instrument, is widely purchased by various healthcare centers in Sweden and available to be administered by legitimated occupational therapists. Even though it meets all the criteria as a standardized instrument, the ADL-taxonomy seems not to be universally used in occupational therapists' daily practices based on the author's experiences from different clinical placements.

There are studies presenting the validity and reliability of the ADL-taxonomy among different patient groups in clinical research, but no studies regarding Swedish occupational therapists' subjective experiences or attitudes in using the ADL-taxonomy in their clinical practice. It is important to explore the opinions that Swedish occupational therapists have based on their clinical experiences using the ADL-taxonomy, and the facts that might affect Swedish occupational therapists' performance in their assessment process.

## Background

### *Activities of Daily Living*

The term ADL was first presented by Katz in his field of gerontology and health services in 1950 (Katz, 1983; Katz et al., 1970). There were two different domains of activities in one's daily living. A collection of activities such as eating, clothing, bathing, and mobility was called basic ADL, while other activities such as transportation, taking medication, food preparation, and shopping were categorized as instrumental ADL. In 2014 the Occupational Therapy Practice Framework published the definition of ADL as "activities that are oriented toward taking care of your own body", and Instrumental Activities of Daily living (IADL) as "activities to support daily life within the home and community that often require more complex interactions than those used in ADL". (AOTA, 2014, p.S41). Nine activity categories were included in ADL: bathing/showering, toileting and toilet hygiene, dressing, eating/swallowing, feeding, functional mobility, personal device care, personal hygiene and grooming, and sexual activity (AOTA, 2014).

According to James and Pitonyak (2019), the term ADL can theoretically apply to all activities that individuals perform routinely in their daily living. Definition of the term ADL in the ADL-taxonomy is limited to those repeating activities related to personal care, housing activities and communication activities (Törnquist & Sonn, 1994). The ADL-taxonomy consists of twelve main activities in the original version: eating and drinking, mobility, going to the toilet, dressing, personal hygiene, grooming, communication, cooking, transportation, shopping, cleaning, and washing (Törnquist & Sonn, 1994).

### *Assessment of ADL*

Assessment refers to methods or tools that are used to collect data, which is one component of the evaluation process in occupational therapy (AOTA, 2015). The goal of the occupational evaluation process is to achieve optimal interventional planning for the specific client (James & Pitonyak, 2019). Selecting an appropriate assessment is important for occupational therapists to initiate their evaluation process. There is always a question in a professional's decision-making process, to use assessment with standardized instrument or non-standardized assessment?

A standardized instrument, presented by Crist (1998), is an evaluation tool that provides valuable information for intervention planning and monitoring progress for the purpose of supporting effective service delivery decisions. Eakin (1989) suggested that occupational

therapists make use of published assessments with good evidence of their reliability and validity. To administer a standardized test, a practitioner needs to be qualified and capable of using the test validly and reliably (Crist, 1998). Standardized assessment tools are important for evidence-based assessment practices in identifying health-related problems, guiding the choice of interventions and monitoring evolution (Lam Wai Shun & Bottari, 2018).

Royeen and Richards (1998) brought up the fact that standardized tests might not be able to measure everything that needs to be measured in some specific situations and that was why non-standardized assessments (for instance observations, checklists, interviews, screening) existed. Royeen and Richards (1998, p 113) had also identified the main reasons that non-standardized assessments were used in occupational therapy: "easy to administer, extensive training not necessary, standardized evaluations often not in existence, inexpensive, highly portable, take little time, often performed in context, typically noninvasive, relatively easy to teach to others for monitoring, and superficially easy to interpret----long scoring methods not required."

Data produced by standardized instruments are more objective compared with data produced by non-standardized methods, in other words, data selected by standardized tests are referenced to an external group while data produced by non-standardized methods has good relevance to the individual client (Dunn,1989). Besides the reasons mentioned above, there are also ethical, political, and legal concerns that might influence occupational therapists relating to the use of standardized tests in their clinical practices (Crist, 1998). Nevertheless, the risk of providing less than optimal rehabilitation intervention was pointed out by Lam Wai Shun and Bottari (2018) when clinicians did not use standardized assessment with established reliability and validity.

### *The ADL-taxonomy*

The ADL taxonomy is a standardized instrument used by occupational therapists to evaluate the ability of individual's activities of daily living. According to Törnquist and Sonn (2022), the focus of the ADL-taxonomy is not on bodily functions but on the description of activity ability and performance results. Clients' preference of activities are considered by providing answer alternatives "will", "can" and "do" (Törnquist & Sonn, 2022). Different praxis

environments and group variation with differed impairments are also taken into consideration. The instrument is available in an original version and three adapted forms for children, people with visual impairments and people with mental disabilities. Activity ability is described at the activity and sub-activity level in the ADL taxonomy. For example, there are three sub-activities included in an activity called “personal hygiene”, namely “wash her/himself”, “bath or shower”, “wash hair”. Activities and sub-activities are related to the International Classification of Functioning, Disability and Health (ICIDH) and described with a mapping of International Coaching Federation (ICF) codes (Socialstyrelsen, 2022). The original version includes twelve activities and forty-seven associated sub-activities. There is also room to add additional activities that can be selected by a client.

According to Svergies Arbtesterapeuter (2023) the ADL-Taxonomy has been used since the early 1990s and is one of the most widely used occupational therapy assessment instruments in Sweden. The instrument is used in many different areas, such as elderly care, the Swedish Social Insurance Agency, habilitation, and rehabilitation (Svergies Arbtesterapeuter, 2023). Occupational therapists can use the assessment form through direct observation or interview. The instrument can also be used by patients for self-assessment.

The validity of ADL-Taxonomy has been strengthened by experts, professional occupational therapists, and users in the instrument's development process (Törnquist & Sonn, 1994; Törnquist et al., 1999). Reliability has been evaluated in individual studies with satisfying results (Törnquist et al., 1999). Törnquist and Sonn (1994) described the ADL taxonomy as a valid assessment of ADL which provided a common language for occupational therapists and a visual depiction of a patient's ADL performance.

### *Occupational therapists and work environment*

All components that might affect the occupational therapy performance should be taken into consideration when discussing use of the ADL-taxonomy in clinical practice. According to Kielhofner's Model of Human Occupation, people encounter different environments which can be conceptually envisioned as three dimensions: physical, social, and occupational environment (Fisher et al., 2017). These dimensions appears in all levels of contexts including the immediate context, the local context, and the global context.

Taking a workplace as an example, physical environment can be different spaces and objects within the office or hospital rooms. Social environment can be for example relationships with colleagues, interactions between clients and themselves, and expectations from others. While occupational environment indicates that, take assessing a client's activity ability as an example, the physical and social components in the immediate environment that the occupational therapist is surrounded by when he/she walks into a room to meet a client, as well as opportunities of doing the assessment at that moment, including timing, structure, and flexibility. At the same time, the immediate environmental factors interact with the local and global context. For example, a homecare facility in the city Malmö belongs to one of the Swedish municipalities, and it is also part of the EU cities. Social norms, laws and regulations within the Swedish society and the political decisions, economic resources, as well as job requirements in the municipality Malmö make a special combination of different contextual levels. Taking all those factors into consideration, the occupational environment in a workplace will never be the same for different occupational therapists.

Environmental impact refers to the demand and constraints, as well as the opportunity and support that the environment has on a particular individual (Fisher et al., 2017). Occupational therapists as individuals have their own experiences and backgrounds. Their personalities, values, and abilities at the professional level are also different. The three dimensions of environmental factors interact with occupational therapists and with each other in all levels of contexts (Fisher et al., 2017). The occupational performances by different occupational therapists can be influenced by all environmental factors at all levels, which makes every intervention unique to each occupational therapist in clinical practice.

### *Clinical practice*

Regarding implementation of evidence-based methods in clinical practice, Grol and Grimshaw (2003) pointed out that there was a gap between inclination and practice. Dunn (2005) claimed that professionals need to engage in evidence-based practice such as using standardized instruments in their evaluation. Dunn (2005) had also introduced the challenges of providing evidence-based practice: the professional must keep apprised of current literature, develop effective communication strategies, understand how to evaluate the evidence available in the literature. A list of factors that affected healthcare professional practice was made by Flottorp et al. (2013) and grouped in seven domains: guideline factors,

individual health professional factors, patient factors, professional interactions, incentives and resources, capacity for organizational change, and social, political, and legal factors. Whether an evidence-based method would be used in clinical practice depends on its characteristic and how easily adopted it is (Grol, & Grimshaw, 2003). Barriers to implementation of evidence was studied by Grol and Grimshaw (2003) and presented in their study: factors at the health-care system level for example financial disincentives; at the level of the patient like patients' expectations; at the individual professional level such as sense of competence and motivation to act; at the health-care team level for example key persons having different opinions; at the health-care organization level such as lack of time or staff; or the wider environment level like culture and norms.

For meeting client-centered goals, the clinical evaluation approach should be individualized (Baum & Law, 2005). One evidence-based program that is designed for one group is not necessarily right for everyone within that group. Occupational therapists need to take various aspects into consideration in their clinical practice. The selection of strategies depends on the organizations they serve and the specific cases they are handling (Baum & Law, 2005).

Implementation of the ADL-taxonomy as a standardized assessment instrument in clinical practice can be as complicated as other evidence-based practices. To study the implementation of assessment using the ADL-taxonomy, researchers need to understand the interaction between occupational therapists and their work environments. Opinions and reflections from licensed occupational therapists who have had experiences in using the ADL-taxonomy in clinical practice could help future practitioners get a broad view of using the ADL-taxonomy in occupational therapy. Due to lack of evidence for occupational therapists' experiences in using the ADL-taxonomy in clinical research, it is important to initiate an interview study with licensed occupational therapists and explore factors that might affect their using experiences of the ADL-taxonomy in clinical practice.

## Aim of study

The aim of this study is to explore Swedish occupational therapists' views and experiences regarding use of the ADL-taxonomy as an assessment instrument in clinical practice.

# Method

The author chose a qualitative design. Semi-structured interviews were conducted with five licensed Swedish occupational therapists. Inductive content analysis was used to analyze the collected data. Qualitative methods are suitable for the purpose of studying the participants' experiences and their subjective views in a specific context (Henricson & Billhult, 2017). Kristensson (2014) has also mentioned that studies investigating the participants' experiences are best suited through qualitative design and interviews.

## Sampling

The author selected purposive sampling to achieve maximum variety. Purposive sampling means, according to Kristensson (2014), that participants are intentionally selected by the researcher for the aim of the study and with as much variation as possible. The variation that the author wanted to achieve was to include participants with different personal factors such as age, years of clinical experience, and current workplaces.

### *Inclusion criteria*

The criteria for inclusion in the study was that the occupational therapists have worked in the Swedish healthcare system for at least one year and had work experience in using the ADL-taxonomy as an assessment instrument within five years.

### *Exclusion criteria*

Groups that are excluded from the study were people who lack a basic understanding of the instrument and lack knowledge of the Swedish language. However, age, gender, and cultural background were not grounds for exclusion.

## Procedure and participants

The author planned to primarily recruit participants through her own network of contacts, which Kristensson (2014) called a convenient sampling. It means that participants who are easily accessible are selected. However, the author was unable to find enough participants who meet the criteria in her own network concerning variation, the snowball sampling was

also used. The snowball method means that the author asks people from their contact networks to recommend someone who is suitable and willing to participate, and in the same way the new participant recommends further another person until enough interviews are completed (Alvehus, 2013). The samples covered various locations including Malmö, Lund, and Växjö. Broad-spectrum workplaces both from the regions and the local authorities were included, such as the hospitals, Children and Youth Clinic, home health care, and forensic psychiatry.

Ten Swedish occupational therapists were invited by the author via e-mails to participate the interview study. Three of them did not respond and two declined. Five occupational therapists expressed their interests and agreed to join the interview study. When the five participants were assembled, the author first contacted them verbally to explain the relevant issues and asked if they wanted the author to contact their workplaces to obtain permissions of the interviews. In that case the author would first send an email of information to each of their managers. When the permissions were granted, the author sent the introduction letters to all participants and booked a scheduled meeting with each one of them. The recruitment was completed in February 2023.

Five Swedish occupational therapists (Table 1) were included in the study. All five participants were female. Their professional experiences ranged from 12 months to over 30 years. As all the occupational therapists reported having used the ADL-taxonomy within five years, this qualified them to give their views.

**Table** 1

*Sociodemographic description of the participants, N=5.*

| Participant | Age, years | Level of education | Additional education | Clinical experience, years | Swedish as first language |
|---|---|---|---|---|---|
| P1 | 25–34 | 3 years of undergraduate education | No | 1–2 | No |

| | | | | | |
|---|---|---|---|---|---|
| P2 | 55–64 | 2.5 years of undergraduate education | Supplementary courses | >30 | Yes |
| P3 | 35–44 | 3 years of undergraduate education | No | 10–20 | Yes |
| P4 | 25–34 | 3 years of undergraduate education | No | 1–2 | Yes |
| P5 | 45–54 | 3 years of undergraduate education | 2years Master in health care | 20–30 | No |

## Data collection

Semi-structured interviews were used to collect data, which was typical of qualitative studies (Henricson & Billhult, 2017). A semi-structured interview is, according to Alvehus (2013), a combination of structured and unstructured interview methods which encourages two-way communication. Flexibility in a semi-structured interview leaves space for the participants to interact with their thoughts and express themselves (Kvale & Brinkmann, 2014;).
All interviews began with questions written in the interview guide (Attachment 1). These questions were structured to guide the participants thinking through all their experiences in using the ADL-taxonomy. For example, how they used the ADL-taxonomy in their assessment process, what kind of challenges they encountered during the process, what opinions their colleagues had about the assessment method, and so on. Open-ended questions were asked after each structured question, for example "what do you mean about this?" and "What if there is no such problem as…?". Before asking a new question, the author would leave a chance for the participants to mention something relevant which caught the participants' mind during the interviews. After the last question, the author left them a moment to think in case they came up with something that was not discussed during the interviews.

Five interviews were all conducted by the author. The interviews took place in different rooms chosen by participants themselves where they felt comfortable expressing themselves. The purpose was to achieve trustworthiness and communicative validity (Alvehus, 2013) of the interview study. The interviews took 25-40 minutes. Data collection was finished in March 2023. All interviews were digitally recorded with the participants' consent and later transcribed verbatim on a computer by the author. Transcriptions were done as soon as possible to ensure the reliability of the memory. All the audio recordings will be destroyed after the examination is finished.

## Data analysis

Inductive content analysis was used for the data analysis. The purpose of the content analysis is to find answers to the studied questions (Höglund & Granskär, 2017). Rather than searching the texts for a pre-determined list of content items, the inductive content analysis is reinforced empirically from a close reading of the texts (Vears & Gillam, 2022). According to Kristensson (2014), content analysis means that the transcribed interviews are processed to find similarities and differences.

Graneheim and Lundman (2004) suggested that the content must be read thoroughly and understood; identified and condensed into meaningful units; abstracted into different codes; and then sorted into categories to get a clear overview. A meaningful unit is a meaning-bearing part selected from the text, which can be words, sentences, or paragraphs that belong together according to the context and its content. A code is a label on a meaningful unit that briefly describes its content. A category consists of several codes with similar content. With condensing and abstracting the meaningful units, Graneheim och Lundman (2004) refer to a process that make the text shorter and easier to manage and raise content to a higher logical level.

The author completed the analysis by herself. Kristensson (2014) recommended that a single author who contacts an interview study by her/himself should discuss data analysis with a supervisor in order to avoid bias. The author made sure that her supervisor had access to all transcribed interviews so that they could discuss the content. The author read the entire text first to get an overall picture of it. Subsequently the author identified meaningful units and condensed them, and then abstracted and named those condensed meaningful units into

different codes. The codes were formulated as text oriented as possible, however some of them were developed with reasonable interpretation. The author condensed and coded five interviews herself and then discussed the coding with her supervisor to make sure that it matched the content of the sentences and the whole context. The codes were compared for identifying similarities and differences, and then sorted into four subcategories and then into two main categories. An example of a category with meaning units, condensed meaning units, codes, and subcategories is presented in Table 2.

**Table 2**

*Meaningful units, coding, and Categorization*

| Meaningful units | Condensed meaningful units | Codes | Subcategories | Category |
|---|---|---|---|---|
| *" Sometimes depending on the patient, you can sometimes stop halfway if you see that they get a little restless and then take it the next time." (P1)* | We can be interrupted halfway in case the patient becomes restless. We will take it next time. | Takes into account the patient's well-being. | Keeping the clients in focus | Trying to be professional |
| *" a child who is 2 years old and a child who is 16 years old and not the same... There is a very big difference between a child who is from zero to eighteen." (P5)* | Big difference between children from zero to 18 years old. | Not divided into age group for children's version. | Reflecting on strength and weakness of the ADL-taxonomy. | Trying to be professional |

## Ethical considerations

One of the characteristics of qualitative interview study is the closeness between the researcher and the participants, which can also mean a risk for credibility of interviews (Kjellström, 2017). Taking this risk into consideration, the author believed that the participants should choose the interview places themselves to avoid potential environmental influence. Some participants chose their own offices that were undisturbed so that they felt comfortable providing data freely. Some participants chose to take online interviews via zoom meetings so that they could do it in their free time without any pressure. The author created zoom meetings with password so that only the participants could join the meetings. These strategies helped strengthen the trustworthiness of the collected data.

According to Kjellström (2017), it is better to provide participants with both oral and written information and give participants enough time for consideration. The author gave all potential participants oral information about the study at the first contact. Later on, the author sent each participant an information letter regarding the purpose of the study, the approach, the responsible person and how the data would be used. All participants were also informed that participation in the study was voluntary and confidential, and they could stop at any time in the procedure without consequences. According to Lag om etikprövning av forskning som avser människor (2023), the information letter to the participants should include information about the research such as aim, planation, method, risks, and legal person, as well as voluntary participation and freedom to cancel at any time. The author obtained written consent from all participants for their participation in this research and maintained records of their consent**.** However, all the participants were able to withdraw their consent at any time without any consequence. The reason was to ensure that all participants involved in the study were truly willing to share their date, which was important to achieve trustworthiness (Shenton, 2004).

Confidentiality, according to Kjellström (2017), means the researchers have the duty to preserve participants' privacy, including storing data securely and reporting data in a way that it will not reveal any individual. The author recorded the interviews using her personal smartphone with password. The transcribed data was stored on the author's personal computer with password. The collected data on individuals was used for research purposes

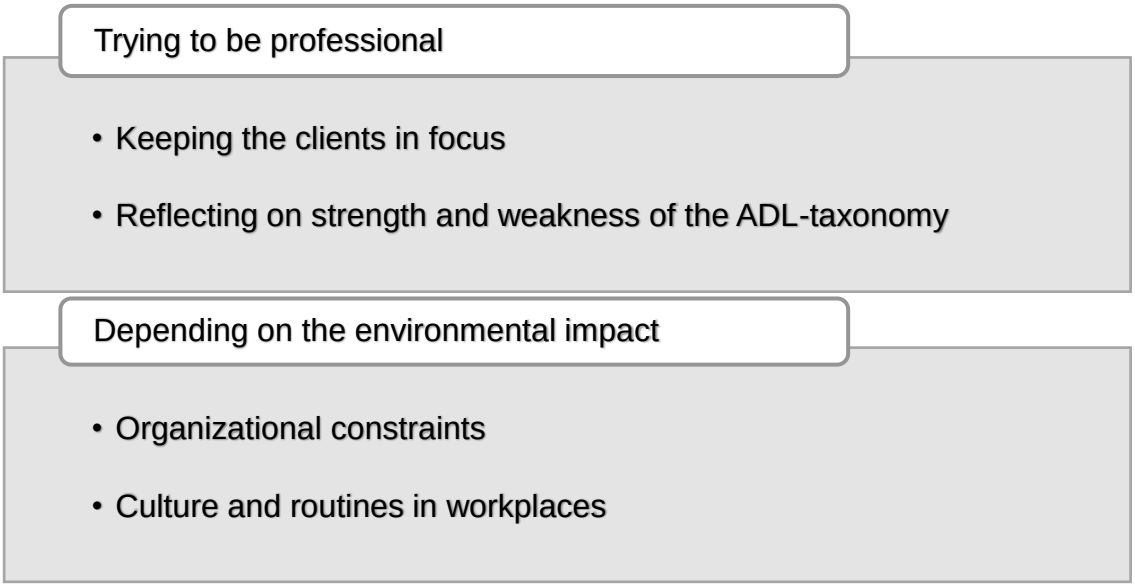
and will be destroyed after the examination. Data reporting was checked a few times to make sure that no individual would be identified by the information presented in the study.

# Results

The analysis showed the experiences and views among occupational therapists in Sweden through the following categories (Figure 1): *Trying to be professional* and *Depending on the environmental impact.*

**Figure 1**

*Overview of Categories and Subcategories presented in the Result.*




## Trying to be professional

This category describes how occupational therapists reflect on their clinical experiences of using the ADL-taxonomy in relation to professional development. Two subcategories are included in this category: *Keeping the clients in focus* and *Reflecting on strength and weakness of the ADL-taxonomy*.

### *Keeping the clients in focus*

The participants mentioned that clients were always in focus regardless of their workplaces. Some participants explained their considerations in providing a comfortable care setting for newly arrived clients. For example, the observation form of the ADL-taxonomy was avoided in case clients with psychiatric disorders had difficulties being observed especially when they were in new environments.

*P1: "when they are new, it is difficult to do observations because they will feel being watched and everything is already too much."*

The timing of assessment was also adjusted according to clients' physical and mental state. One assessment of the ADL-taxonomy could be done on two separate occasions if the client needed. The reason was usually clients' poor physical strength, however it could also be that clients felt mentally disturbed during the process.

*P1: "sometimes depending on the patient, you can sometimes stop halfway if you see that they get a little restless, and then take it the next time."*

The interviews showed that occupational therapists respected clients' views and tried to invite them in formulating goals no matter how old they were. If clients could express their own ideas and were willing to participate, they would always be included in planning individual interventions.

*P5: "I had a girl who could describe her difficulties... And then it was like she who came up with the ideas then."*

### *Reflecting on strength and weakness of the ADL-taxonomy*

Most participants expressed positive attitudes toward using the ADL-taxonomy in clinical practice. The reliability and validity of the instrument were highly valued by the participants.

*P3: "it is well developed and proved, that you have a standardized instrument to base your assessment on and that it is used in the same way by all occupational therapists."*

Some participants mentioned that they used the ADL-taxonomy as a form of checklist and felt more certain in their roles when they were new in the workplace. The practice of using

standardized instruments was viewed by the participants as a prominent issue to qualify themselves as licensed occupational therapists.

*P5:"I see a great advantage with standardized instruments to consolidate professionalism as an occupational therapist. Credibility, professionalism and of course also for research."*

According to the interviews, decision makers in Sweden often used the evaluation results of the ADL-taxonomy, for instance, social workers from municipalities used the results to make decisions for clients' applications of home care services.

*P3: "Biståndshandlägare wants a statement to see how much help they need and whether they need help, so that we go there and do one of them."*

The results was also used by clients in their applications as evidence to strengthen their need for housing adaptations, or for increased services and support according to the Swedish Act concerning Support and Service for Persons with Certain Functional Impairments (LSS).

*P5: "I also use it in the intervention and write it in the statement if it should be sent to some kind of housing adaptation or if it should be sent to LSS as a certificate."*

Some occupational therapists stated that they found the ADL-taxonomy easy to use based on their earlier training and experiences, and they did not usually bring the assessment form when they did the evaluation.

*P5: "I don't think I'll pick up the instrument itself that I have it in paper form... I have it in the back of my mind every time I do an interview."*

Regarding clients' priorities, there were participants who said that the ADL-taxonomy provided possibilities to include activities chosen by clients. The reason was that the ADL-taxonomy had empty room for additional activities which clients might mention themselves during the process of assessment. There were also participants who claimed that the ADL-taxonomy did not allow individuals to identify and prioritize their daily activities.

*P3: "The instrument does not take into account whether the patient can actually do it physically but does not want to or wants to but cannot."*

The reliability of the interview form and self- assessment form was discussed as a negative aspect. Many occupational therapists chose to combine the interview form and the observation form. The explanation was that there could be differences in results by using

different assessment forms. For example, one client said that he had no problem visiting the toilet, but problems were identified by occupational therapists during the observation.
The self- assessment form was also found negative in reliability especially for psychotic patients who had problems understanding differences between reality and imagination.
Another problem concerning the details in sub-activities was mentioned in the interviews. More sub-activities could be included under the main activities based on more detailed components of each activity. For example, taking a shower was included as one sub-activity under the main activity, personal hygiene. However, there were different steps in taking a shower which could be divided into more sub-activities.

*P3: "Sometimes questions arise about what ability is included in what activity... I cannot take a shower, but in which part..."*

One critical issue mentioned in the interviews was that the Swedish society had changed rapidly in digital technology development, but the instrument was not up to date in activities such as communication in using smartphone or iPad.
Another weakness was also mentioned by participants regarding the children's version. The ADL-taxonomy lacked classification of the age range on clients under 18 years old. According to the participants, most of the assessment instruments regarding children and adolescents were segmented into different age groups based on huge ability differences. However, the children's version of the ADL-taxonomy had no such division regarding age groups.

*P5: "a child who is 2 years old and a child who is 16 years old and not the same... There's a very big difference between a child who is like that from zero to 18."*

Many participants thought that using the ADL-taxonomy meant doing a whole assessment of all activities that were included in the assessment form, which would take time and effort for both patients and occupational therapists.

*P2: "But it's a whole assessment on everything."*

### Depending on the environmental impact

This category describes how occupational therapists reflect on the environmental factors within different contexts that affect their practices. Two subcategories are included in this category: *Organizational constraints*, and *Culture and routines in workplaces*.

### *Organizational constraints*

Organizational structures in different systems were often found to constraint occupational therapists' practices. To achieve the goals of an organization, there were usually rules, roles, and responsibilities outlined in the organization from the top down according to the interviews. The responsibilities of the rehabilitation team were clearly distributed in the hospital. For example, occupational therapists were responsible for evaluation and documentation of activities like personal hygiene and clothing, while activities like transportation and movement would be taken care of by physiotherapists. Similar issues were also presented by other participants in different workplaces.

*P4: "Then we don't use all the parts … Of course, we look at movement, but that is for the physiotherapists usually…"*

The average length of hospital stay was also considered as a challenge for occupational therapy. Some participants said that they wanted to keep the patients for a longer period in the hospital so that they could have time to complete an entire process of intervention with them. However, the length of hospital stay was so incredibly short, and they felt a high pressure from the organizational level. Most patients were moved to residential care or home care as soon as possible to continue their rehabilitation.

*P4: "We might have wanted to rehabilitate with the patients for a longer time, but. But we do not get that because the length of care is so incredibly short, that external aspects are absolutely that there is so little time, and that there are regulations from higher up. The patients should go on and rehabilitate at home or yeah, at the residential care and it is absolutely very sad."*

There was also participants who expressed dissatisfaction about the organizational approach. For example, there was a lack of communication between different parties involved in one client's health care. Due to the Swedish law about patient confidentiality, they had no right to share documentations between different parties, for example between the hospitals and home care facilities. The occupational therapists from the hospital had no right to follow up their patients after they were dismissed.

*P4: "No, unfortunately we have almost no follow-ups with our patients. We almost never get to know how things are going on with them after discharge, but it is the municipality that*

*takes over."*

### *Culture and routines in workplaces*

Work culture was one important issue for the participants in their clinical practice. The participants meant that there were behavior patterns created by staff over a long time in every organization. These unwritten rules and attitudes would affect their decisions and ways of doing things. All participants felt affected by the culture in their workplaces and reflected on their work routines. Participants felt more confident in those workplaces where they were provided with introduction and tutoring by experienced colleagues in the beginning. Reflections of using experiences were discussed frequently, which promoted the implementation of the ADL-taxonomy. For example, in some workplace occupational therapists discussed a lot about how to use the ADL-taxonomy and produced a same routine that every occupational therapist should follow in their assessment.

*P1: "We have discussed a lot... especially the ADL taxonomy, we have made it clear that we all do the same, ... We are going to use the interview form...".*

There was also some workplaces where occupational therapists did not use the ADL-taxonomy in their daily practice unless they were asked to do it for special reasons, for instance, to write a statement for decision makers. According to the participants, they were all influenced by the culture in the workplace.

*P2: "There may be a bit of culture here too that you don't use this, maybe partially. I don't know if anyone uses it."*

The journal systems in different workplaces were concerned dominantly for their work routine. Most of the participants adapted their work routines to the content in the journal systems. For example, under the subtitle the ADL assessment, there were a list of headings such as personal hygiene, toilet visit, eat and drink, and so on, which was similar to the content of activities in the ADL-taxonomy. They followed the headings listed in the journal system when they initiated an ADL assessment.

*P4: "We don't write that we've used the ADL taxonomy for example, but we write under all these headings so that what we write documentation for everything we see and everything we do. We use Melior."*

According to some interviews, to write a documentation of an assessment with the ADL-taxonomy would be double work since there were already similar headings followed by phase texts in the journal system.

*P2:" Most of the headlines in the ADL taxonomy are in the journal system Procapita. If you write there it's kind of double-documented."*

# Discussion

## Result discussion

This study is aimed at exploring Swedish occupational therapists' views and experiences of using the ADL-taxonomy in clinical practice. The results showed that Swedish occupational therapists felt professional when they used the ADL-taxonomy in their clinical practice, however whether they chose to use the ADL-taxonomy in a specific case and how they would use it during the assessment depended on the environmental factors surrounding them.

The results bring up relevant components of being professional, namely reflecting on evidence-based practice such as using the ADL-taxonomy, as well as focusing on client-centered practice. These results match the theory of professionalism in occupational therapy, which includes to "… pursue excellence by maintaining competency and demonstrating evidence-based practice and scholarship" and to "…subordinate self-interest, by being aware of society's needs, maintaining a client-centered practice…" (Falk-Kessler, 2019, p. 557). At the same time, the data suggests that environmental impact plays a significant role in occupational therapists' daily clinical practice. The expectations that they have on themselves as licensed occupational therapists and the influence of the environmental factors in all levels of contexts interact with one another, which highlights the complexity of clinical practice.

Regarding the use of evidence in healthcare professional practice, previous research has focused on finding the relevant factors that affect professionals' practice (Flottorp et al., 2013). However, the results in this study describe a complicated situation that occupational therapists experience between professional development and environmental impact. The environmental impact on one occupational therapist can be completely different from another occupational therapist. To develop professionally, the participants want to use the ADL-

taxonomy in their daily practice. However, there is a gap between encouragement and reality for some of the participants.

According to Fisher et al. (2017), the environmental impact can provide opportunity for professional development, it can also indicate hindrance and constraints to the professional development process. An occupational therapist's immediate context interacts with the local and global contexts, which makes a special combination of environmental factors. Take social environment as an example, Fisher et al. (2017) means that it shall be considered at all levels of contexts, namely immediate, local, and global context.

Expectations from other health care professionals and work colleagues, as one social environmental component in immediate context, could affect the quality of occupational therapy. For example, in some workplace occupational therapists stated that they gained competence in using the ADL-taxonomy through instructions and tutorial training, and constant exchange of their experiences and reflections between colleagues improved their skills and knowledge. The supportive social environment in the workplace provides opportunities for their professional development. On the other hand, some participants experienced their social environments as challenges and constraints when using the ADL-taxonomy in their practices. Take the distribution of responsibilities in a team as an example, it could challenge occupational therapists in doing a whole ADL assessment using the ADL-taxonomy. The reason was that assessment of activities like movement and transport were distributed to physiotherapists as teamwork in hospitals.

Culture and routines, as social environmental factors in occupational therapists' local context, are considered as principal issues in their practices. One common phenomenon mentioned by the participants was that the documentation work in journal systems appeared to dominate their work routine. For instance, instead of using the ADL-taxonomy assessment form, some participants chose to follow the headings of ADL assessment in the journal system when they started an evaluation. This is because they tried to avoid double work of documentation to achieve efficiency. Equivalent results such as usual routines and lack of time in practice environment were presented as barriers to implementation of evidence-based methods in Grol and Grimshaw 's study (2003). In short, work culture and usual routines in the local context can affect an occupational therapist's decisions and clinical performance.

The social components can also be experienced at the society level in global context (Fisher et al., 2017). Some participants considered laws and policies in Swedish society as obstacles in communication among different health care systems. Part of the assessment process could be interrupted by organizational constraints, for example following up a client's interventional results in the re-evaluation process. The occupational therapists from hospitals had no rights to read the journal of their patients when they were moved to another health care facility.

Depending on whether the environmental factors were supportive or discouraging, the occupational therapy performances by Swedish occupational therapists differed a lot in different workplaces. There could be consequences in professional development when the environmental factors are unsupportive. For example, there were differences in professional knowledge levels and competence levels among licensed occupational therapists regarding use of the ADL-taxonomy. Some occupational therapists always followed the instructions of the ADL-taxonomy, and constantly improved their skills through training and reflections. Conversely, in a less supportive environment, occupational therapists did not have mentoring or reflection sessions. There appeared to be misunderstandings of how to use the ADL-taxonomy. For example, there were participants who thought that using the ADL-taxonomy meant a whole assessment of all the activities listed in the assessment form, while the first step, according to the instruction (Törnquist & Sonn, 2022), was selecting relevant activities at the time of assessment. There were also participants who said that the ADL-taxonomy did not allow individuals to identify and prioritize their daily activities, which was contrary to the demonstration. According to Törnquist and Sonn (2022), the ADL-taxonomy illustrates a difference between what activities the person actually does and what they are willing to do, which makes goal settings easier concerning activities prioritized by the client.

These results should be taken into consideration when discussing how to use reflection, supervision and mentoring to engage in evidenced-based occupational therapy (Falk-Kessler, 2019). There are ethical codes attached to the legitimation of professionals (Lundgren & Molander, 2008). One of the ethical codes for occupational therapists is to "participate in professional development through life-long learning and apply their acquired knowledge and skills in their professional work, based on the best available evidence." (World Federation of Occupational Therapists, 2016). It is important to adhere to ethical principles for licensed occupational therapists, however, the environmental impact cannot be ignored when discussing professional development.

## Methodology discussion

In quantitative studies, statistical methods are usually applied to establish validity and reliability of the findings; however, design and methodological strategies are often used in qualitative studies to enhance the credibility or trustworthiness of study findings (Noble & Smith, 2015). The author will discuss the methodological strategies used in the qualitative interview study that strengthen the trustworthiness of the findings in the following rubrics: *Sampling*, *Data collection*, and *Data analysis*.

### *Sampling*

With the goal of reaching maximum variation, purposive sampling was chosen to include occupational therapists with different personal factors such as age, years of clinical experience, and workplaces. Personal backgrounds could have an impact on participants in developing knowledge and competence of using the ADL-taxonomy. However, choosing participants from one's own networks could increase the risk of bias (Kristensson, 2014). Kristensson (2014) means that convenient sampling risks leading to a reduced variety. Therefore, great effort was put into obtaining a broader variety of participants by using the snowball method. The participants varied widely in age and clinical experience. Furthermore, the samples covered broad-spectrum workplaces such as the hospitals, Children and Youth Clinic, home health care, and forensic psychiatry, which was considered satisfactory based on the inclusion criteria. Recruiting participants within several organizations helps achieve site triangulation which is one key component of building trustworthiness in qualitative study (Shenton, 2004). On the other hand, due to the lack of data on other locations except Växjö, Lund and Malmö, the results could not confirm similarities or differences of environmental impact in other local contexts in Sweden. Considering there are four different versions of the ADL-taxonomy, data on using the ADL-taxonomy on people with visual impairments need to be collected in future studies.

### *Data collection*

Semi-structured interviews with open-ended questions were used instead of structured interviews. This could encourage the participants to interact with their thoughts and express

themselves (Kvale & Brinkmann, 2014;). The places for interviews were chosen by each participant individually. Kristensson (2014) believes that interviews should be conducted in a place to make participants feel comfortable and relaxed so that they can be free to express themselves. This would help ensure participants' honesty when contributing data. The participants were also given opportunities to end their participation at any time. For ensuring trustworthiness, the data collection should only involve the people who genuinely want to participate and share data freely (Shenton, 2004).

Due to the reason that the author was the only interviewer, all interviews were carefully recorded and transcribed verbatim on the same day by the author to prevent memory loss. One issue that should not be ignored was that there were participants who were not native speakers of Swedish. This could influence the precision of speech in Swedish language, which is important for effective communication (Nwankwo, 2023).

### *Data analysis*

The author chose inductive content analysis because it was well-suited to use in relatively small- scale, non-complex qualitative research (Vears & Gillam, 2022). Vears and Gillam (2022) point out that interpretation of data is a critical step in the inductive analysis process. To avoid bias and stay close to the phenomenon, the author kept a constant discussion with her supervisor. Steps like coding and developing subcategories or categories were done several times by the author and reflected with the supervisor in the end. The researcher should use the help of his or her superiors through frequent discussion to recognize his or her own preferences and biases, which would contribute to trustworthiness of the qualitative study (Shenton, 2004).

## Conclusion

The ADL-taxonomy is well known as a standardized assessment method among occupational therapists in Sweden. Even though the validity and reliability of the ADL-taxonomy are proved by previous studies, evidence in practice experiences using the ADL-taxonomy as occupational therapists is still missing in clinical research. By interviewing the Swedish occupational therapists, this study has discovered a complexity of occupational therapists'

views and experiences using the ADL-taxonomy as an assessment method in clinical practice. Whether they would choose the ADL-taxonomy as an assessment method and how they would use the ADL-taxonomy during the process depended on the specific patient and the environmental factors that they were surrounded by at that moment.

The occupational therapists' inner expectations of being professional interact with external environmental influences in several ways. For example, they felt professional when they used the ADL-taxonomy in their clinical practice and they also tried to use it in a complete occupational therapy process, namely evaluation, intervention, and re-evaluation. However, implementation of the method differed between patients, as well as environments. Depending on the combination of physical, social, and occupational environment, the environmental factors can be either supportive or discouraging for occupational therapists' clinical practice using the ADL-taxonomy. The occupational therapists felt more confident in using the ADL-taxonomy when the environmental factors were supportive and felt disturbed or reserved when the environmental factors turned out to be discouraging. Consequently, there became differences in knowledge and competence levels among the occupational therapists regarding use of the ADL-taxonomy. This result suggests a need for introduction programs for new occupational therapists and increased reflection sessions among experienced occupational therapists regarding assessments with the ADL-taxonomy.

Further research is needed to make more sense of the relation between professional development and environmental impact. Supportive environmental factors for implementation of evidence-based methods should be strengthened at higher level in the Swedish health care systems, such as alleviating organizational constraints and creating better work routines. Furthermore, observational studies are required to gain more insight into different patterns of usage of the ADL-taxonomy among Swedish occupational therapists. Future studies should consider covering a larger area in Sweden and including participants using the ADL-taxonomy on more patient groups.

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Attachment 1

**Intervjuguide**

Frågor om personlig bakgrund

1. Hur lång grundutbildning har du? Har du någon vidareutbildning eller specialistutbildning?
2. Hur många års klinisk erfarenhet har du som arbetsterapeut?
3. Vilka verksamheter har du jobbat i och vilka typer av patientgrupper har du jobbat med?
4. Vad är din nuvarande anställning?
5. Är svenska ditt modersmål?
6. Hur gammal är du?

Intervjufrågor, exempelfrågor

1. Hur ser du på att använda standardiserad instrument som arbetsterapeut? Vad tillför det i ditt arbete som arbetsterapeut?
   Hur ser du på relationen mellan klientcentrerat arbete och användning av standardiserade instrument?
2. Hur tror du att andra yrkesgrupper ser på arbetsterapeutiska standardiserade instrument?
3. Finns det ADL-taxonomin tillgänglig och används i verksamheten du jobbar i nu? Har du fått instruktion eller handledning för att använda ADL-taxonomin i ditt yrkesliv?
4. Brukar du använda ADL-taxonomin i ditt dagliga arbete?

<u>Om ja/ibland</u>

-När använder du den och i vilka sammanhang?-Hur använder du den, i bedömning? planering? uppföljning? journalföring?

-Berätta om ett tillfälle när du använd ADL-taxonomin i arbetet med en patient

-Hur tycker du det fungerar att använda ADL-taxonomin?

Bra, på vilket sätt? Kan du ge några exempel?

Några negativa aspekter som du upplever i samband med användning? Några konkreta exempel?

<u>Om nej</u>,

-Vad är det som gör att du inte använder ADL-taxonomin i samband med utredning/bedömning?

Är det du själv som väljer att inte använda det?? Varför? (inneboende orsak)

Finns det externa faktorer som har påverkat dig? (yttre orsak) Vilka konkreta exempel kan du berätta om?

-Användaer du ADL-taxonomin som ett redskap för att formulera klientcentrerade mål? Hur gör du?

5. Finns det någon kollega som du kan diskutera med om ADL-taxonomin och användningen av instrumentet?

Om ja, vad brukar ni diskutera då?

Om nej, varför tror du det är så?

**Avslutande frågor**

- Hur uppfattar du instrumentet som helhet och hur det används?
- Har du något du vill tillägga utöver det vi redan pratat om?