

1. INTRODUCTION

The Assessment of Motor and Process Skills (AMPS) is an innovative observational evaluation designed to be used by occupational therapists to evaluate the quality of a person's performance of activities of daily living (ADL) in natural, task-relevant environments. The development and design of the AMPS has been based on three critical assertions:

- *All occupational therapy services must be client-centered.* This means that we must strive to understand the client and the client's circumstances from the client's own perspective. Then, we must focus our evaluations, interventions, and reevaluations on those daily life tasks that present as challenges or problems for the client, and which the client has prioritized as wanting or needing to perform.
- *Our evaluations, our interventions, and our reevaluations must be both occupation-focused and occupation-based.* This means that our evaluation methods and our intervention strategies are based on the client's engagement in occupation. It also means that occupation should be the focus of what we communicate to our clients and our colleagues.
- *The occupational therapy process is most effective when organized in a true top-down manner.* This means that our evaluation of the client should first focus on developing a broad picture of the client, the client's circumstances, and the client's needs and desires in relation to daily life task performance. Then, after the client identifies the tasks that the client considers as challenges or problems, and which the client wishes to perform more effectively, the occupational therapist observes the client perform those tasks. During the observation, the occupational therapist focuses on the client's quality of occupational performance, including which occupational performance skills were effective and ineffective during the task performance. Only then does the occupational therapist consider the causes of the client's ineffective occupational performance (Fisher, 2009).

While these beliefs are central tenants of our profession, they can be difficult to infuse into occupational therapy practice. Our hope is that using the AMPS as an

evaluation tool will help occupational therapists offer their clients a richer, more client-centered, occupation-based, and true top–down approach to occupational therapy. To that end, the goal of this manual is threefold:

- To provide occupational therapists with the information necessary to administer, score, interpret, and document the results of an AMPS observation in a valid and reliable manner;
- To demonstrate how to incorporate and use the AMPS in a client-centered occupation-based, and true top–down approach to occupational therapy; and
- To provide the occupational therapist with an understanding of the validity and reliability of the AMPS, including the evidence which supports using the AMPS in occupational therapy practice.

1.1 Unique Features of the AMPS

One of the most unique features of the AMPS is that it is a standardized ADL performance analysis. Whereas the items scored on most ADL tests are personal (self-care) and/or instrumental (domestic) ADLs, the items scored on the AMPS are ADL performance skills. Performance skills are the universal, goal directed ADL motor and ADL process actions that are compiled to enact ADL task performances. More specifically, performance skills are the smallest units of observable action (occupational performance) that are linked together, one after another, in the process of executing a daily life task performance. For example:

As Kathleen folds a basket of laundry, she (a) reaches for, chooses, grasps, and lifts a red shirt (ADL skill items Reaches, Chooses, Grips, and Lifts); (b) alters her grasp to support the shirt and shakes the wrinkles out of the shirt with an appropriate amount of force (ADL skill items Handles and Calibrates); and (c) begins to fold the shirt (ADL skill item Initiates). As she continues to fold the shirt, she pinches the button while putting it through the buttonhole, folds over the sides of the shirt, and then aligns the folded edges of the shirt (ADL skill

items Continues, Manipulates, and Notices/Responds). Action by action she enacts her ADL task performance.

We think of ADL task performance as one type of occupational performance (which also includes performance of school, work, leisure, and other types of daily life tasks). Occupational performance can be described as a chain of actions. The performance skills (ADL skill items) are the actions or individual links that must be connected together to construct the more global, larger whole — the chain (the occupational performance) (see Figure 1-1). Each action is a link in the chain. Each action is the smallest unit of observable ADL task performance (e.g., reaching for the shirt, lifting the shirt), and is *goal-directed because it is enacted in the context of carrying out and completing an ADL task* that has been chosen by the client (e.g., to fold a basket of laundry). *Occupational performance, therefore, is the sum of linked, observable, goal-directed performance skills.*

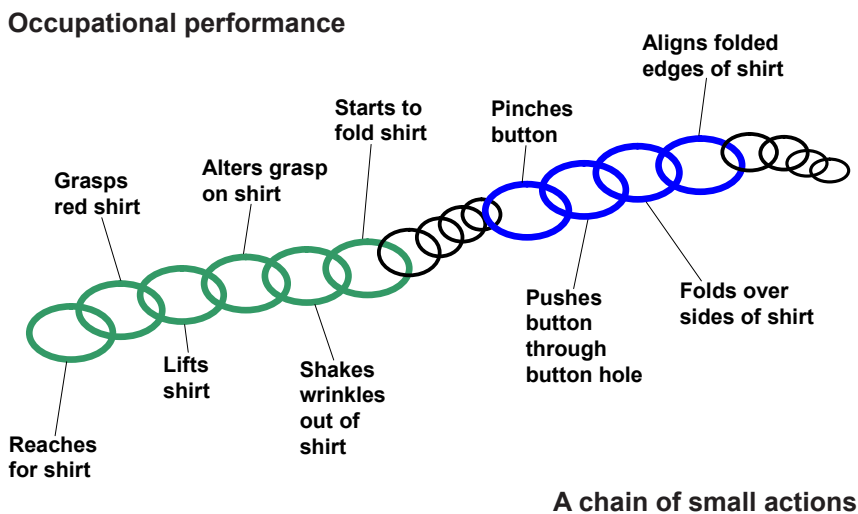


Figure 1-1. Performance skills: Smallest observable units of occupational performance — links in a chain of actions performed one-by-one as the person “constructs” the overall task performance. (Adapted from Fisher, A. G. [2009]. Occupational Therapy Intervention Process Model: A model for planning and implementing top-down, client-centered, and occupation-based interventions. Ft. Collins, CO: Three Star Press. With permission.)

We call these actions performance skills because when we observe a person performing a task, we might observe more or less skilled task performance. When we observe skilled performance, the individual actions the person performs will be observable and recognized as skilled actions (e.g., skilled reaching, skilled choosing). Likewise, if the person carries out a task performance that reflects less skill, at least some of the actions the person performs will be observable and recognized as reflecting less skill (e.g., ineffective manipulation, ineffective initiating) (Fisher, 2006b, 2009).

Because it is the quality of each of the 16 ADL motor and 20 ADL process performance skills (ADL skill items) that is scored when the occupational therapist administers the AMPS, *the AMPS is a highly sensitive evaluation of ADL ability*. More specifically, the occupational therapist uses a 4-point rating scale to score each ADL skill item. A score of 4 reflects skilled (competent) performance and a score of 1 indicates very unskilled (severely deficient) performance. The ADL skill items are listed in Table 1-1. See Chapter 2 for an introduction to the ADL skill items.

The AMPS has several additional features that make it a unique evaluation of ADL ability:

- *The AMPS is an occupational therapy-specific evaluation tool* that focuses on the quality of a person's ADL task performance, not the underlying person or environmental factors that may support or limit the person's quality of ADL task performance.
- *The AMPS has been standardized on more than 150,000 persons, 2 to over 100 years of age, internationally and cross-culturally.*
- The AMPS is designed to allow for *culture-relevant evaluation while remaining free from cross-cultural bias*. This becomes possible because the ADL tasks included in the AMPS have been standardized to allow for cross-cultural variations in how persons perform otherwise similar tasks, and each person observed is allowed to perform such tasks in a manner expected, given the person's cultural background.
- The administration of the AMPS requires *no special equipment*, and the AMPS can be administered in *any task-relevant setting* within a 30 to 40 minute period.

Table 1-1 ADL Motor and ADL Process Skills that are Operationally Defined in the AMPS

ADL motor skills	ADL process skills
<i>Body position</i>	<i>Sustaining performance</i>
Stablizes	Paces
Aligns	Attends
Positions	Heads
<i>Obtaining and holding objects</i>	<i>Applying knowledge</i>
Reaches	Chooses
Bends	Uses
Grips	Handles
Maipulates	Inquires
Coordinates	
<i>Moving self and objects</i>	<i>Temporal organization</i>
Moves	Initiates
Lifts	Continues
Walks	Sequences
Transports	Terminates
Calibrates	
Flows	<i>Organizing space and objects</i>
	Searches/Locates
	Gathers
	Organizes
	Restores
	Navigates
<i>Sustaining performance</i>	
Endures	
Paces	
	<i>Adapting performance</i>
	Notices/Responds
	Adusts
	Accommodates
	Benefits

- The AMPS can be *administered to persons 2 years of age and older*, for whom there is concern about ADL task performance.
- The AMPS can be used to assess *(a) persons with any type of diagnosis or disability; (b) well persons; and (c) those who have not yet received a formal diagnosis, but who may be at risk for functional decline.*

- The AMPS was developed using a *many-faceted Rasch (MFR) measurement* model (Fisher, 1993; Linacre, 1993, 2009). Our use of MFR analyses has enabled us to convert each person’s raw ordinal ADL motor and ADL process item scores into *linear ADL motor and ADL process quality of performance measures that are adjusted to account for (a) the relative challenge of each of the tasks the person performed, as well as (b) the severity of the occupational therapist who observed and scored the person’s performance.*
- The unique design of the AMPS allows the occupational therapist to *compare the quality of performance* of a person who performed different AMPS tasks each time he or she was evaluated. In a like manner, the AMPS can be used to compare performances among groups of persons who each performed a different set of AMPS tasks.
- The AMPS provides occupational therapists with a *powerful and sensitive tool* that can assist in planning effective interventions and documenting the effectiveness of occupational therapy interventions.
- The AMPS provides *a vocabulary* that the occupational therapist can use *to describe the quality of a person’s occupational performance* — what and how a person does what he or she needs and wants to do, given the demands of the ADL task and the resources and demands of the physical and social environment.

1.2 Overview of the AMPS

1.2.1 AMPS Administration Process

In order to enable a naturalistic and client-centered observation of the quality of a person’s ADL task performance, the occupational therapist begins the AMPS administration process by conducting a detailed occupational therapy interview.

This interview includes obtaining information from the client about what daily task performances are of most concern, as well as the circumstances that set the context for the client’s daily life task performances. If the client identifies ADL tasks as an area of concern, and prioritizes certain ADL tasks that are also included in the AMPS (see Volume 2, Chapter 3, AMPS Task Descriptions), the occupational therapy interview

continues as the occupational therapist introduces the idea of administering an AMPS observation.

If the client is in agreement with the idea of engaging in an AMPS observation, the occupational therapist begins to focus the interview on the types of AMPS tasks the client identified as problematic, including (a) the specific tools and materials the person typically uses when performing those tasks, and (b) the essential elements that must be included for each AMPS task to be performed in a standardized manner. In this way, flexible AMPS task options are matched to the abilities, needs, interests, and cultural background of the person.

As the interview progresses, the occupational therapist narrows a list of potential AMPS task options to a shorter subset of approximately three to five relevant tasks that provide the person a sufficient level of challenge. This subset of tasks is then offered to the person, and, from this subset, the person chooses at least two tasks to perform.

After the occupational therapist has observed the person perform each AMPS task, the occupational therapist scores the quality of the person's observed performance in relation to each of the 16 ADL motor and 20 ADL process skills. These scores are then entered into the occupational therapist's personal copy of the AMPS computer-scoring software. Provided the occupational therapist is a calibrated AMPS rater, he or she can then generate a variety of reports that can be used to interpret and document the results of the person's AMPS observation.

1.2.2 Standardized AMPS Tasks with Flexible Options for Cross-cultural Evaluation

Since the AMPS is standardized internationally and cross-culturally (see Chapter 15), it is imperative that we recognize that task familiarity and relevance are heavily influenced by the cultural background of the person being evaluated (Goldman & Fisher, 1997; Magalhães, Fisher, Bernspång & Linacre, 1996). To meet the demand for task options appropriate for persons from diverse backgrounds and with diverse needs, interests, and levels of ability, over 110 standardized ADL tasks (with flexible tasks options) are currently included in the AMPS manual.

Each of the over 110 AMPS tasks is represented in a unique task description found in Volume 2, Chapter 3, AMPS Task Descriptions. The task description for each AMPS task includes *specific task guidelines* (i.e., **Essential task** and **Specific criteria**) that provide sufficient requirements for each task to be standardized, yet are

flexible enough to allow each person to perform the tasks in his or her usual manner using the tools and materials he or she typically would use. In addition, *flexible task options* (i.e., **Options**) (see Volume 2, Chapter 3, AMPS Task Descriptions) also allow for the diversity of methods people use cross-culturally to perform otherwise comparable tasks. For example, to perform an AMPS task that involves brewing a pot of coffee or tea, the person is free to specify if he or she will brew coffee or tea; and if the person chooses to brew coffee, whether he or she will boil the coffee, use a French press, or make the coffee in an electric coffee maker. Brewed tea is the more common option chosen by persons in the United Kingdom and Asia, whereas persons from the United States or the Nordic countries are more likely to brew coffee. The use of a French press may be an option chosen by a client from Europe, Australasia, or North America, while boiled coffee tends to be unique to northern Sweden, Alaska, and parts of New Zealand. See Chapter 2 for an introduction to AMPS task descriptions.

Each of the over 110 AMPS task descriptions include specific guidelines for standardization, and flexible task options to allow for cross-cultural application.

1.2.3 AMPS Scoring Criteria

The scoring criteria in the AMPS manual (Volume 2, Chapter 8, AMPS Skill Items) reflect the quality (ease, efficiency, safety, and independence) of each of the smallest units of observable action (ADL skill items) as well as the impact of diminished performance skill on the quality of the overall ADL task performance. The result is a *highly sensitive evaluation of occupational performance*.

The scoring criteria for the ADL motor and ADL process skill items are based on specific scoring examples that pertain to the person's quality of performance of ADL tasks. For example, the ADL process skill item Heeds relates to the person's effectiveness at completing the task in the manner that was agreed upon by the occupational therapist and the client prior to beginning the task. When the occupational therapist uses the scoring examples to rate the person's heeding skill when performing the ADL task of folding a basket of laundry, the occupational therapist scores the ADL skill item Heeds as competent (i.e., a score of 4) when the occupational therapist

observes the person to ***readily and consistently*** use goal-directed task actions that are focused toward carrying out and completing the laundry folding task (i.e., the expected outcome: all of the laundry folded), using task materials that were specified. In like manner, the occupational therapist gives a score of 3 when the occupational therapist observes the person to have heeding skill that possibly disrupts the task performance or possibly impacts other ADL skill items. The occupational therapist gives a score of 2 when the occupational therapist observes the person to have ***ineffective*** heeding skill that disrupts the task performance or other ADL skill items, or results in inefficient use of time or increased physical effort (e.g., the person receives a score of 2 for Heeds if he or she folds most of the laundry, but does not fold the towels or leaves the towels only partially folded). Finally, the occupational therapist scores the person's heeding skill as ***severely deficient*** (i.e., a score of 1) if the occupational therapist observes the person to have a severe heeding skill deficit that results in unacceptable delay, unacceptable effort, task breakdown, imminent risk of damage to task objects or danger to the person, or need for assistance (e.g., the majority of the laundry is not folded, the person is cued to fold the laundry).

1.3 Limitations of the AMPS

While there are many advantages of the AMPS, making it an innovative observational assessment, there also are some limitations that arise because of its unique design:

- The AMPS is not suitable for evaluation of children under the age of 2 or for persons who have no need or who are unwilling to participate in simple daily life tasks.
- ***If the AMPS is to be used for documenting the efficacy of occupational therapy interventions, quality assurance, or research, it must be computer-scored.*** The AMPS computer-scoring software is used to compute overall, linear ADL motor and ADL process ability measures that have been adjusted to account for the challenge of the ADL tasks the person performed and the severity of the occupational therapist who scored the

person's performance. The use of raw item or total scores for documenting efficacy of interventions or in other forms of research is never valid.

- The AMPS computer-scoring software is provided only to occupational therapists who participate in AMPS training and calibration workshops.
- Because the estimation of a person's quality of performance measures must take into account the relative severity of the AMPS rater, occupational therapists who take AMPS training courses cannot generate AMPS computer-generated reports until they have successfully completed rater calibration requirements.

The use of AMPS item or total raw scores for documenting efficacy of intervention or for research is never valid.

1.4 Rater Calibration Requirements

In the process of developing the AMPS, we have found that valid and reliable administration and interpretation of the AMPS requires that occupational therapists (a) participate in a training course, and (b) become calibrated as a rater. The training workshops provide critical information related to the theoretical basis of the AMPS as well as experiential learning of the AMPS administration and scoring procedures. Rater calibration requires that potential raters view and score videotaped AMPS observations during the course and then complete 10 live observations after the course. A crucial component of AMPS training is the practical experience that is obtained through scoring AMPS observations during the training course and the completion of rater calibration procedures following the course. Rater calibration allows us to determine if the occupational therapist is scoring the AMPS in a reliable and valid manner. We also use rater calibration to determine each occupational therapist's personal rater severity calibration value. This calibration value is used in the AMPS computer-scoring software to adjust the person's ADL motor and ADL process ability measures to account for the severity of the rater who scored the person's performance.

2. DEFINITIONS OF TERMS AND KEY CONCEPTS

The focus of this chapter is to define terms and introduce key concepts found within the AMPS manuals and the AMPS computer-scoring software. As these terms and concepts are used throughout the AMPS manuals and software, they are crucial to understand prior to learning how to administer and score the AMPS. For definitions of terms related to many-faceted Rasch analyses, see Chapter 14.

2.1 Defining Activities of Daily Living

We will be referring to activities of daily living as ADL. By ADL we mean both personal ADL (PADL) and instrumental ADL (IADL). To further clarify:

- **PADL:** Personal or basic activities of daily living related to self-care (e.g., brushing teeth, dressing, eating)
- **IADL:** Instrumental or domestic activities of daily living related to home maintenance and required for independent living (e.g., cooking, housework, gardening, shopping)

2.2 Defining the Client

We will use three different terms to refer to the client (Fisher, 2009).

- **Person:** We will use the term “*person*” to refer specifically to ***the person who seeks or was referred for occupational therapy services***. This includes the person being evaluated using the AMPS. Examples are a patient, a student, a customer/consumer, or a person seeking preventative occupational therapy services.

- **Client constellation:** We will use the term “*client constellation*” to refer to *both the person and others who live with, work with, or are otherwise closely connected to the person*. Examples include (a) a patient and his or her close family members (typically those who live with the person); (b) a customer/consumer who is attending a day treatment center and the staff who are working with that person on a regular basis; (c) a student in an elementary classroom and his or her teacher; or (d) a well, older adult participating in a wellness program and the staff who are working with him or her on a regular basis. *The persons included in the client constellation are only those who experience problems of occupational performance in relation to working or interacting with the person who seeks/was referred to occupational therapy.*
- **Client:** Finally, we will use the term “*client*” to refer to *either (a) the person who seeks/was referred to occupational therapy or (b) the client constellation*. For example, in Chapter 1 we wrote, “the tasks that the client identifies as problems.” We used the term “*client*” in order to refer to either the person who was referred for occupational therapy services, and/or other members of his or her client constellation who expressed concerns about occupational performance, specifically tasks that are problems for the person to perform.

2.3 Defining Clinic and Home

The AMPS can be administered in either a clinic or a home setting. These terms are defined as follows:

- **Clinic:** Any environment that is not the client’s home environment or where the client is living. Hospital or clinical settings, classrooms, and day treatment centers are therefore considered to be clinic settings.
- **Home:** Any setting, other than a hospital, where a client is currently living is considered a home environment. This means that houses and apartments, as well as assisted-living, group, and nursing homes are considered to be home environments.

2.4 Defining Performance Analysis versus Task Analysis

Occupational therapists commonly implement both performance analyses and tasks analyses. As *both are based on observation of the client performing daily life tasks*, it is important to clarify the difference between them (refer to Fisher, 2009 for further discussion, including the difference between performance, task, and activity analyses).

- **Performance analysis:** Observation and evaluation of the quality of a person's daily life task performance, without consideration of how underlying impairments, person factors¹, or environmental factors may be supporting or limiting the person's performance (i.e., without interpretation of the cause or reason for effective or ineffective occupational performance). For example, when the occupational therapist observed Kathleen fold a basket of laundry, she observed and evaluated the quality of each action in the chain of actions Kathleen performed as she (a) reached for, chose, grasped, and lifted the shirt; (b) altered her grasp to support the shirt and shake the wrinkles out of the shirt; and (c) began to fold the shirt. More specifically, each action was evaluated in terms of the amount of observed physical effort, efficiency, safety, and independence with which the Kathleen folded laundry (see Chapter 1, Section 1.1).
- **Task analysis:** Observation, evaluation, and analysis of a person's daily life task performance with the express intention of defining the cause or reason for effective or ineffective occupational performance. If an occupational therapist observes a person folding laundry and assesses the environmental factors, person factors, and underlying impairments of body functions that impact the person's laundry folding, the occupational therapist is administering a task analysis.

The AMPS is a standardized method of completing a performance analysis. In the AMPS, we focus on ADL task performance. In other contexts, the focus of

¹ Person factors, referred to as personal factors within the *International Classification of Functioning, Disability and Health* (ICF) (World Health Organization, 2001), include all factors except body functions that are internal to the person and define the client-centered performance (e.g., age, habits and routines, roles, gender, ethnicity, educational background, sociocultural background) (Fisher, 2009).

a performance analysis may be work, school, or other daily life task performances (Fisher, 2009; Fisher, Bryze, Hume & Griswold, 2007; Fisher & Griswold, 2009).

2.5 Introducing the AMPS Task Descriptions

Volume 2, Chapter 3, AMPS Task Descriptions, contains a detailed description of each standardized task that is included in the AMPS. Each task description is organized with consistent headings. Each of the headings is discussed below.

- Each task **title** globally describes the task (e.g., Task B-2. Toast and boiled/ brewed coffee or tea — one person).
- The **Essential task** description defines the basic performance elements required for standardization of the task. These basic performance elements describe the global standardization task criteria, and may help the occupational therapist determine if the task is relevant to the culture of the person.
- The **Specific criteria** further define the standardized task criteria, including providing more detailed information that will help determine the relevance of the task to the person.
- The task **Options** tell the occupational therapist how the task can be varied to allow for individual preferences and cultural differences.
- **Restoration** tells the occupational therapist about the criteria for putting task tools and materials away and returning the workspace to its original condition.
- The **Prior to beginning, the person should** section reminds the occupational therapist about what the person must do prior to the task observation so that the person becomes fully familiar with the task environment.
- The **Prior to beginning, the occupational therapist should** section reminds the occupational therapist that he or she must do certain things before observing the person. Almost always, this includes ascertaining specific information from the person that informs the occupational therapist about the person's intentions (e.g., what ingredients he or she intends to use).

- The **Special rule(s)** provides guidelines about scoring the task observation.
- The **Required tools and materials** list alerts the occupational therapist to the necessary tools and materials that must be in the space in order for the task to be performed without contriving any elements.

2.6 Introducing the ADL Skill Items

The AMPS is comprised of 16 ADL motor and 20 ADL process skill items.

- ADL motor skills are the observable, goal-directed actions a person performs in order to move him- or herself or task objects while interacting with the task objects and environment as he or she performs an ADL task.
- ADL process skills are the observable, goal-directed actions a person performs as he or she (a) selects, interacts with, and uses task tools and materials; (b) logically carries out individual actions and steps of an ADL task; and (c) modifies his or her performance when problems occur.

Each of the ADL motor and process skills are also *universal* goal-directed actions. They are universal because they comprise and support all ADL task performances. For example, whether a person makes a sandwich, cleans a bathroom, or rakes leaves, he or she must reach for, grip, and lift the task objects. Similarly, he or she must search for and locate the needed tools and materials, gather them to the workspace, and sequence the steps of the task performance in a logical order.

Each ADL skill item (see Table 1-1) is defined and described in detail in Volume 2, Chapter 8, AMPS Skill Items. Because Volume 2, Chapter 8 is the definitive resource for scoring all ADL skill items, ***the occupational therapist should read and use Volume 2, Chapter 8 when scoring every AMPS task observation.*** It is impractical, if not virtually impossible, to memorize the scoring criteria included in Volume 2, Chapter 8 — we do not recommend that anyone try.

Valid and reliable scoring of the AMPS requires that the occupational therapist always read and use Volume 2, Chapter 8, AMPS Skill Items, when scoring each AMPS observation.

The occupational therapist may find that the names of some of the ADL skill items are similar to terms that are frequently used in his or her current occupational therapy frame-of-reference (e.g., Stabilizes, Coordinates, Attends). However, even though the ADL skill items are familiar terms, there are often large or subtle differences between (a) the AMPS definitions, and (b) the “everyday” definitions of the same words or their “traditional” definitions in various frames-of-reference. *Therefore, we strongly recommend that, when implementing the AMPS, the occupational therapist “let go” of the everyday or traditional definitions and commit to learning a new “AMPS” language.* Not doing so, or imposing assumed definitions on the ADL skill items, will guarantee that the occupational therapist scores unreliably, resulting in invalid AMPS results.

The format for each ADL skill item found in Volume 2, Chapter 8, AMPS Skill Items, is organized as follows:

- The **name** of the ADL skill item is always at the top of the page.
- The **Key Concept(s)** remind the occupational therapist of the main focus of the ADL skill item.
- The phrase “*The occupational therapist observes the person to*” reminds the occupational therapist to score what he or she observed and not his or her interpretation of what was observed. Said in other terms, this statement is intended to remind the occupational therapist to implement a performance analysis, not a task analysis (see Section 2.4).
- The paragraph that starts “**4 = readily and consistently**” broadly defines competent performance of the ADL skill item. This paragraph is important because it is the AMPS-related operational definition of the ADL skill item. *If*

the occupational therapist requires clarification of the precise definition of the ADL skill item, he or she should return to this paragraph. If the quality of the action that the occupational therapist observed is consistent with this definition, then no problem with this ADL skill was observed.

- The section that starts “**3 = have questionable**” describes the criteria required for the occupational therapist to give the ADL skill item a score of 3. Usually, a score of 3 is given when the occupational therapist observed the person perform the ADL skill item and questioned if there was a problem that impacted the task performance or another ADL skill item. In general, the occupational therapist will assign few scores of 3.
- The section that starts “**2 = have ineffective**” operationally defines ineffective performance of the ADL skill item (i.e., the impact the diminished quality of performance of the action had on the task performance or on other ADL skill items). This section usually contains several examples that further clarify the operational definition of ineffective performance. The occupational therapist should carefully read all of the examples in this section. If the action the occupational therapist observed matches (or is similar to) the examples listed in this section, then the person would receive a score of 2 for the ADL skill item.
- The section that starts “**1 = have severe**” operationally defines the level of impact a severe deficit of the ADL skill item would have on the task performance or on other ADL skill items. There are usually examples which the occupational therapist should read carefully to ensure that what he or she observed does or does not match these examples.
- The *Note* at the bottom of each ADL skill item definition clarifies where certain observed actions are scored. When the statement begins with “Score,” it is a reminder that the observed action is to be scored under a different ADL skill item, *not* the one where the note is located (e.g., the statement “Score active bending too close to the workspace under *Positions*” in the note for Aligns indicates that such actions are to be scored under Positions, not Aligns). Another type of note alerts the occupational therapist as to when an observed action should be scored under more than one ADL skill item (e.g., the statement “Instability

when walking is also scored under *Walks*” in the note for Stabilizes informs the occupational therapist to consider such actions when scoring both Stabilizes and Walks). Finally, the note may include further description of specific rules or guidelines that apply when scoring the ADL skill item.

3. ADMINISTRATION OVERVIEW: PLACING THE AMPS IN THE OCCUPATIONAL THERAPY INTERVENTION PROCESS

As discussed in Chapter 1, one of the goals of this manual is to assist the occupational therapist in effectively integrating the AMPS into his or her occupational therapy practice. To that end, we will use the Occupational Therapy Intervention Process Model (OTIPM) (Fisher, 1998, 2009) to conceptualize and explain the many steps that an occupational therapist implements when practicing occupational therapy in a client-centered, occupation-based, and top-down manner. We use the OTIPM because it provides us with a clear, step-by-step description of the occupational therapy intervention process. In this chapter, we will provide an overview of the OTIPM, and we will continue to use the OTIPM throughout this manual to clarify the context in which the AMPS is administered.

We will conceptualize the occupational therapy intervention process as beginning with the initial referral to occupational therapy, and ending when the occupational therapist reevaluates to determine if the provided services have been effective and discharges the client. In doing so, we recognize that some occupational therapists work in settings where the full range of possible occupational therapy services cannot be provided. For example, some occupational therapists work in settings where evaluation and recommendations for further services represent the full range of occupational therapy services that may be provided. Additionally, occupational therapy services may be discontinued at other phases in the process, prior to reevaluation, for a variety of reasons (e.g., determination of no need for occupational therapy services, sudden illness or even death of the client).

We also recognize that some occupational therapists work with clients who are not referred to occupational therapy. Instead, their clients actively seek occupational therapy services without the need for a referral. We use the term “*initial referral*” to encompass both when a client seeks occupational therapy services and when a client obtains a referral in order to access occupational services.

Figure 3-1 shows the stages of the occupational therapy intervention process as conceptualized in the OTIPM. The complete occupational therapy intervention process includes four global phases: evaluation, intervention planning, intervention

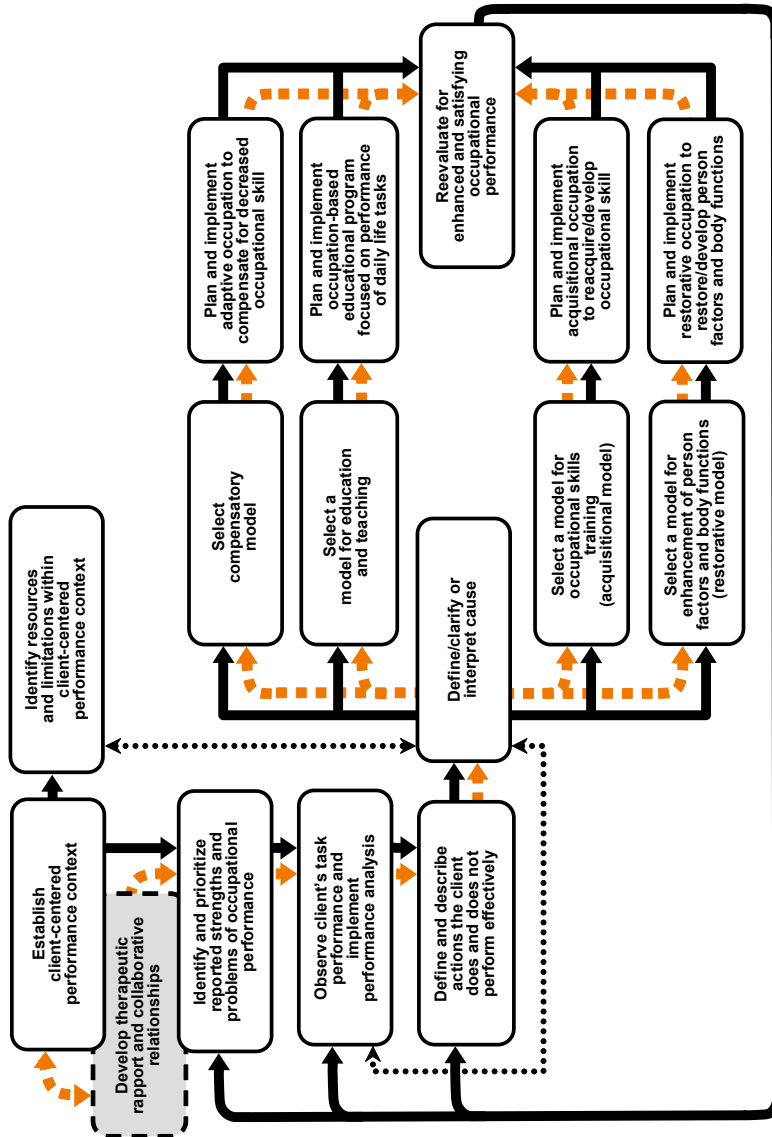


Figure 3-1. Occupational Therapy Intervention Process Model. (From Fisher, A. G. [2009]. Occupational Therapy Intervention Process Model: A model for planning and implementing top-down, client-centered, and occupation-based interventions. Ft. Collins, CO: Three Star Press. Reprinted with permission.)

implementation, and reevaluation. More specifically, after obtaining an initial referral, the occupational therapist begins the intervention process by initiating the evaluation phase, and gathering broad information related to ***establishing the client-centered performance context***. The client-centered performance context provides the occupational therapist with a global view of the many internal factors (e.g., motivational, body functions) and external factors (e.g., environmental, societal) that may influence a client's occupational performance. This information, which is comprised of 10 dimensions, provides the context for what each client does, why the client does it, how the client does it, and whether or not the client performs needed and desired daily life tasks effectively. The majority of this information is gained during the occupational therapist's interview of the client. Often, the focus of the occupational therapy interview is on the person who was referred to occupational therapy, but the focus may also be on another person in the client constellation who is experiencing problems with occupational performance².

During the occupational therapy interview, the occupational therapist also helps the client identify those daily life task performances that are strengths and those that present problems for the client. The client, in collaboration with the occupational therapist, then prioritizes which of the problematic daily life task performances to focus on first (***identify and prioritize strengths and problems of occupational performance***).

Once the client has established which daily life tasks are priorities, the occupational therapist implements a performance analysis of the prioritized tasks. If the tasks prioritized include ADL tasks, the occupational therapist may choose to administer the AMPS as a standardized performance analysis of ADL task performance (***observe and implement performance analyses***). Finally, after determining the results of the performance analysis (***define actions that the client did and did not perform effectively***), the occupational therapist considers the reasons for the person's problems of occupational performance (***define/clarify or interpret cause***).

We feel that it is important to stress the importance of following a true top-down evaluation and professional reasoning process. Notice that the occupational

² We refer to a "person" as the AMPS is administered to individuals, not groups of persons. We recognize that occupational therapy services are legitimately provided to all members of the client constellation who experience problems of occupational performance in relation to the person who seeks/was referred to occupational therapy. Occasionally, therefore, it will be a member of the client constellation, not the person who sought/was referred whom the occupational therapist observes during an AMPS evaluation.

therapist begins broadly by gathering information about the client, and then focuses on occupation — those daily life task performances that are relevant to the person being evaluated. As the occupational therapist focuses in on occupation, the evaluation process progresses from global (which task performances are reported as strengths and which are of concern) to specific (which actions, or performance skills, are effective and which are ineffective). Recall that performance skills are the smallest observable units of occupational performance. This means that up to and including the step where the occupational therapist defines the actions (performance skills) that the person does and does not perform effectively, the occupational therapy evaluation has stressed occupational performance and not underlying body functions or environmental or person factors that may be “causing” the person to have problems with occupational performance. Those factors that may be contributing to the person’s problems with occupational performance are not addressed until later in the occupational therapy intervention process, and only as needed.

When the AMPS is fully integrated into the occupational therapy intervention process, the AMPS administration procedures progress over nine phases. These nine phases are shown in Table 3-1 in relation to the occupational therapy intervention process as conceptualized in the OTIPM. Phase I covers initiating the process of establishing the client-centered performance context and therapeutic rapport, and the preparation needed prior to administering the AMPS in the occupational therapist’s work setting. Phase II focuses on the occupational therapy interview, and includes establishing the client-centered performance context and having the client identify and prioritize what daily life tasks will be the focus of further evaluation and possible intervention. Phase II also includes Part 1 of a standardized AMPS performance analysis: introducing the AMPS and establishing the task-specific client-centered performance context. Phase III encompasses the observation of a person’s ADL task performances, Part 2 of a standardized AMPS performance analysis. Phase IV addresses scoring the AMPS, Part 3 of a standardized AMPS performance analysis. Phase V consists of (a) entering client-related data and ADL motor and ADL process raw scores into the AMPS computer-scoring software, and (b) generating AMPS reports. This phase is Part 4 of a standardized AMPS performance analysis. Phase VI pertains to the final part of a standardized AMPS performance analysis, the interpretation and documentation of the results of an AMPS observation, including grouping actions that the person does and does not perform effectively into clusters for more thorough documentation.

Table 3-1 Phases of AMPS Administration in Relation to the Occupational Therapy Intervention Process Model (OTIPM)

Occupational therapy intervention process	AMPS administration
<i>Initial referral</i>	
<p><i>Evaluation phase</i></p> <ul style="list-style-type: none"> • Establish the client-centered performance context • Develop therapeutic rapport and collaborative relationships 	<p><i>Phase I (Chapter 5) — AMPS administration preparation</i></p> <ul style="list-style-type: none"> • Initiate the process of establishing the client-centered performance context and developing therapeutic rapport and collaborative relationships • Prepare for the occupational therapy interview <p><i>Phase II (Chapter 6) — Occupational therapy interview</i></p> <ul style="list-style-type: none"> • Frame the nature and purpose of occupational therapy • Establish the global client-centered performance context and simultaneously continue to develop therapeutic rapport and collaborative relationships
<ul style="list-style-type: none"> • Identify resources and limitations within the client-centered performance context 	<p><i>Phase II (Chapter 6) — Occupational therapy interview</i></p> <ul style="list-style-type: none"> • Identify resources and limitations within the client-centered performance context
<ul style="list-style-type: none"> • Identify and prioritize reported strengths and problems of occupational performance 	<p><i>Phase II (Chapter 6) — Occupational therapy interview</i></p> <ul style="list-style-type: none"> • Identify strengths and problems of ADL task performance • Identify the client's priorities • Determine whether to administer the AMPS

(continued)

Table 3-1 (continued)

Occupational therapy intervention process	AMPS administration
<p>Evaluation phase (continued)</p> <ul style="list-style-type: none"> Observe client's task performance and implement performance analysis: Performance analysis, Part 1 — determine constraints of daily life task to be performed Observe client's task performance and implement performance analysis: Performance analysis, Part 2 — observe daily life task performance Observe client's task performance and implement performance analysis: Performance analysis, Part 3 — Rate quality of observed goal-directed task actions 	<p>Phase II (Chapter 6) — Occupational therapy interview</p> <ul style="list-style-type: none"> Introduce the AMPS Establish the preliminary task contract Establish the task-specific client-centered performance context <p>Phase III (Chapter 7) — Observe and implement a performance analysis</p> <ul style="list-style-type: none"> Summarize the task contract and initiate the task observation Observe the person perform at least two AMPS tasks in a task-relevant environment Take observational notes <p>Phase IV (Chapter 8) — Score the AMPS observation</p> <ul style="list-style-type: none"> Record the person's information on the AMPS Score Form Rate the overall quality of occupational performance for each task Rate the person's functional level Score each AMPS task observation
<ul style="list-style-type: none"> Define and describe actions the person does and does not perform effectively: Performance analysis, Part 4 — Create computer-generated reports summarizing the client's quality of observed performance <p>Note. This part of a performance analysis is only possible if the occupational therapist enters the person's data into the AMPS computer-scoring software.</p>	<p>Phase V (Chapter 9) — Enter the person's raw scores into the computer-scoring software and generate AMPS reports</p>

(continued)

Table 3-1 (continued)

Occupational therapy intervention process	AMPS administration
<p>Evaluation phase (continued)</p> <ul style="list-style-type: none"> Define and describe actions the client does and does not perform effectively; Performance analysis, Part 5 — Cluster and summarize goal-directed task actions performed effectively and not effectively; document results of the performance analysis 	<p>Phase VI (Chapter 10) — Interpret and document the person’s AMPS results</p> <ul style="list-style-type: none"> Interpret the person’s ADL motor and ADL process ability measures relative to a criterion of competence Interpret the person’s ADL motor and ADL process ability measures using a norm-based perspective Interpret the person’s ADL motor and ADL process ability measures in relation to the person’s potential need for assistance for community living Summarize the person’s overall quality of performance Define and describe actions the person does and does not perform effectively Group actions the person does not perform effectively into meaningful clusters Document the person’s AMPS results
<ul style="list-style-type: none"> Establish the client’s goals <p>Note. This step is not shown as occurring at a specific phase of the OTIPM as it can occur anywhere during the evaluation phase. Goals must be established before the therapist progresses to the next phase of the intervention process</p>	<p>Phases II to VI — Establish the client’s goals</p> <ul style="list-style-type: none"> Collaborate with the client to identify and write the client’s goals for enhanced ADL task performance
<ul style="list-style-type: none"> Define/clarify or interpret the cause 	<p>Phase VII (Chapter 11) — Define and interpret reasons for the person’s ineffective ADL performance</p> <ul style="list-style-type: none"> Determine what resources/limitations within the client-centered performance context contribute to the person’s ineffective task performance (consider each meaningful cluster)

(continued)

Table 3-1 (continued)

Occupational therapy intervention process	AMPS administration
<p><i>Intervention planning phase</i></p> <ul style="list-style-type: none"> • Select compensatory, acquisitional, restorative, and/or education and teaching model(s) 	<p><i>Phase VIII (Chapter 11) — Plan and implement occupation-based intervention</i></p> <ul style="list-style-type: none"> • Select compensatory, acquisitional, restorative, and/or education and teaching model(s)
<p><i>Intervention implementation phase</i></p> <ul style="list-style-type: none"> • Plan and implement adaptive occupation, acquisitional occupation, restorative occupation, and/or an occupation-based education program 	<p><i>Phase VIII (Chapter 11) — Plan and implement occupation-based intervention</i></p> <ul style="list-style-type: none"> • Plan and implement one or more of the following: <ul style="list-style-type: none"> ○ Adaptive occupation ○ Occupational skills training ○ Person factors or body functions training ○ An occupation-based education program
<p><i>Reevaluation phase</i></p> <ul style="list-style-type: none"> • Reevaluate for enhanced and satisfying occupational performance 	<p><i>Phase IX (Chapter 12) — Reevaluate for enhanced ADL task performance</i></p> <ul style="list-style-type: none"> • Readminister the AMPS • Generate a Progress Report and evaluate the effectiveness of provided occupation-based intervention

Phase VII involves defining and interpreting the reasons for a person’s ineffective ADL performance. Phase VIII pertains to using the results of an AMPS observation to plan and implement occupation-based occupational therapy interventions. Finally, Phase IX encompasses the role of the AMPS in reevaluation, including documentation of the efficacy of occupational therapy services.

In this manual, we address each of the nine phases of AMPS administration in Chapters 5 through 12. Included in each of these chapters is a case illustration, based on a 65-year-old woman named Bev. In addition, Chapter 4 covers the initial steps an occupational therapist must follow to prepare to administer the AMPS for

the first time. In Chapter 13, we address special considerations for administering the AMPS to persons with specific limitations, including persons who have difficulty communicating during an occupational therapy interview and those who may deny any difficulty performing ADL tasks. Finally, in Chapters 14 and 15, we discuss how the AMPS was developed and summarize the available evidence supporting the reliability and validity of the AMPS.

4. AMPS INITIAL PREPARATION

In this chapter, we discuss the initial preparation required for the administration of the AMPS. This preparation is crucial for ensuring valid and reliable AMPS observations. *This initial preparation is typically completed just once, prior to administering the AMPS for the first time. That is, the occupational therapist usually finds that after this initial preparation, he or she can prepare for most occupational therapy interviews and AMPS observations without returning to this phase.* There may be situations, however, where this phase needs to be repeated, either partially or in full.

The steps of the AMPS initial preparation are outlined in Table 4-1. Because this initial preparation happens outside of the time the occupational therapist spends with his or her clients, there is no parallel phase within the Occupational Therapy Intervention Process Model (i.e., this phase is not shown in Figure 3-1 or Table 3-1).

Table 4-1 The AMPS Initial Preparation Phase

Step 1:	Committing to using the AMPS
Step 2:	Considering available spaces for administering the AMPS
Step 3:	Identifying possible AMPS task options given the available spaces, tools, and materials
Step 4:	Determining relevant AMPS task options for a client population
Step 5:	Ensuring familiarity with the AMPS global task option list
Step 6:	Addressing concerns regarding the appropriateness of the AMPS for a client population

Once the occupational therapist carefully completes the preparation process we describe in this chapter, he or she will have created a list with a broad range of AMPS tasks to offer his or her clients. This list is called the *global AMPS task option list*. To create a global AMPS task option list, the occupational therapist must reason through a series of questions to determine which of the more than 110 AMPS tasks included in the AMPS manual (see Volume 2, Chapter 3, AMPS Task Descriptions) might be appropriate options for his or her client population. The goal of this preparation

process is to have as many task choices available for testing as possible. Only those tasks that are clearly irrelevant should be omitted.

The occupational therapist must always strive to include all possible task options on his or her global AMPS task option list. He or she should only omit those tasks that would never be relevant to the population of clients with whom the occupational therapist works.

4.1 Step 1: Committing to Using the AMPS

The first step in preparing to administer the AMPS is to commit to using the AMPS. In order to do this, the occupational therapist needs to reflect on his or her practice and consider these questions:

1. Do I work with clients who have and/or express that they have problems with occupational performance?
2. If so, within what areas of occupation do they have concerns that they need and/or want to address in occupational therapy?
 - a. PADL?
 - b. IADL?
 - c. Work?
 - d. School?
 - e. Play/leisure?

It is well known that the scope of occupational therapy services can span all areas of occupation, including not only ADL, but also work, school, and/or play/leisure activities. If the occupational therapist's practice consists of at least some clients who have problems with ADL, then there is a reason to make the commitment to use the AMPS with those clients. For example:

Ling is an occupational therapist serving four acute medical units in a local private hospital. The people that she sees are primarily concerned with returning home as quickly as possible. The tasks that they usually identify as personal priorities are PADL tasks which range from brushing teeth to showering and getting dressed. Some clients also are concerned about how they will prepare simple meals for breakfast or lunch. The vast majority of her clients do not identify housekeeping tasks or large meal preparation tasks as concerns at this stage in their recovery or rehabilitation. Given Ling's client base, and their interest in self-care and simple meal preparations, Ling will commit to using the AMPS with the majority of her clients.

Ernesto is an occupational therapist serving a large community group home for persons with developmental disabilities. Each person living in the group home is responsible for preparing his or her own breakfast and lunch, and helping with either cooking or cleaning up after the evening meal. Each person is also responsible for chores like making his or her bed, folding his or her laundry, and other household chores like vacuuming, dusting, and cleaning the bathroom. Finally, there is a large yard and garden which each person in the home helps maintain. Ernesto sees the persons living in the group home whenever one or more of them are experiencing problems performing the required IADL tasks expected at the group home. Therefore, he committed to using the AMPS in order to assess the ADL task performances that present problems to his clients.

Jeff provides occupational therapy services to clients in supported work centers. His clients usually report having problems completing their work duties, which include serving food, assembling gift baskets, or packing boxes for shipping. Jeff spends his time addressing work-related issues with his clients. If his clients do have problems with ADL, they are to seek services from a community-based occupational therapist. After considering his clients' concerns and problems, and the type of services he can provide at the work centers, Jeff decided not to use the AMPS because assessing ADL is not relevant to the problems his clients report concerning their work tasks within their supported work environments.

Anna works with very young children, under 2 years of age. Because the AMPS is standardized for use with children 2 years of age and above, Anna realized that the AMPS would not be relevant to her occupational therapy practice.

4.2 Step 2: Considering Available Spaces for Administering the AMPS

Once the occupational therapist determines that assessing ADL ability is relevant to her or her clients and commits to using the AMPS, the next step is to reflect on the spaces where he or she sees clients. *The occupational therapist should consider the availability of natural, task-relevant environments needed to carry out AMPS observations* — environments that are relevant to his or her clients and their needs, interests, and abilities. More specifically, the occupational therapist can reflect on the following questions:

1. Do I have **kitchen spaces** available in which to test my clients, either in their homes or in my clinic? If so, are the kitchens:
 - a. Distraction free?
 - b. Equipped with a refrigerator, stove, sink, cupboards, drawers, and needed dishes and utensils?
 - c. Similar to the kitchens in my clients' homes? Or are the cupboards filled with splinting materials or other therapy supplies?

2. If I have determined that cooking tasks are relevant, but do not have kitchen spaces available, how can I solve this problem?
 - a. Can I remove unneeded supplies from the cupboards?
 - b. Can I purchase needed cooking utensils or supplies?
 - c. Can I advocate for needed spaces, tools, and materials?

3. Do I have **bathrooms** available in which to test my clients, either in their homes or in my clinic? If so, are the bathrooms:
 - a. Distraction free?
 - b. Equipped with a toilet, shower or bathtub, and a sink?

- c. Available for assessing clients? Or are they used as storage spaces for equipment (e.g., wheelchairs, walkers, therapy balls)?
4. If I have less than ideal bathroom spaces, how can I make the spaces more desirable?
 - a. Can I bring in needed equipment?
 - b. Can I remove those things that might be in the way?
5. Do I have **bedrooms** or **other living areas** available in which to test my clients, either in their homes or in my clinic? If so, are the living areas:
 - a. Distraction free?
 - b. Equipped with sheets, pillowcases, blankets, and/or relevant furniture (e.g., chairs, sofa, lamps)?
 - c. Available for assessing clients? Or are they used as storage spaces for equipment (e.g., wheelchairs, walkers, therapy balls)?
6. If I do not have an actual bedroom and/or other living area, is there a room with a bed and/or a room with chairs, table, and/or a sofa that I can use to assess my clients?
7. Do I have **outdoor spaces** (e.g., patios, walkways, gardens) available in which to test my clients, either in their homes or in my clinic? If so,
 - a. Have I been using these spaces when working with my clients?
 - b. Is there any reason why I could not start to use these spaces when working with my clients?

We need to observe and evaluate ADL task performances in natural spaces: bedrooms, family or living rooms, kitchens, gardens — ones like those where the client typically would be performing ADL tasks.

What is critical is that the spaces we use for AMPS observations are natural and like those where the client would typically perform ADL tasks. For example, people

typically have some privacy when completing their morning grooming routines. They do not typically wash their faces, shave, and brush their teeth in noisy bathrooms with strangers walking in and out. Similarly, when people make sandwiches, they usually use kitchens that are supplied with a variety of food and cooking supplies. They do not usually make sandwiches in a kitchen that only has the food and supplies needed to make one sandwich, nor do they make sandwiches in a kitchen cluttered with splinting supplies, long-handled reachers, walkers, or lots of other people. ***When considering available spaces, the occupational therapist may need to make changes to possible testing environments to make them more like natural, home settings.*** For example, in a busy clinic, the occupational therapist may need to set up a schedule or post “do not disturb” signs in order to “reserve” the kitchen or other ADL space, thus eliminating strangers from accessing the environment during the ADL observation.

If all the available spaces are in a clinic, the clinic kitchen should be stocked with a variety of culturally-relevant nonperishable and semi-perishable food supplies (e.g., spreads for toast and sandwiches, coffee and tea for beverages, instant soup or beverage mixes, containers of beans or soup). The occupational therapist can consider the possibility that perishable foods may need to be purchased and brought in the day of the AMPS observation. Other tools or materials that can be routinely stored in the occupational therapy clinic include plants and the needed supplies to repot them, laundry and housekeeping supplies, an iron and ironing board, and miscellaneous clothing that can be folded, washed, or ironed. If testing persons outdoors is an option, brooms, rakes, and other gardening supplies also can be stored in the clinic. The tools and materials that should be available will be determined by the spaces that are available for testing, as well as the interests and needs of the clients who will be assessed (i.e., the specific ADL tasks they need and want to perform).

It is imperative to keep in mind that if the clinic is highly adapted, crowded, or chaotic, it becomes difficult, if not impossible, to implement a valid assessment. More information on setting up the task environment and ensuring that it is similar to the one the person is familiar with is discussed in Chapter 6.

4.3 Step 3: Identifying Possible AMPS Task Options Given the Available Spaces, Tools, and Materials

After the occupational therapist has committed to use the AMPS and considered what natural, task-relevant environments are available where ADL tasks might routinely be performed and observed, the occupational therapist must begin to determine which tasks included in the AMPS can be performed in each of the available spaces, given the available tools and materials. At this phase, the occupational therapist should start creating a list of potential AMPS tasks — *the global AMPS task option list*. *This list should include as many tasks as possible that can be performed in the available spaces with the available tools and materials.* To do this, the occupational therapist will need to consider his or her available spaces while reading Volume 2, Chapter 3, AMPS Task Descriptions. Referring to the index of AMPS tasks (Volume 2, Chapter 3, Section 3.1, Index of AMPS Task Choices) will help the occupational therapist gain familiarity with the names of the tasks, but he or she will also need to *read the complete task descriptions to get a thorough understanding of what is involved and required for each task.*

There is a heading in each task description, **Required tools and materials**, which lists what tools and materials are required, including if a certain type of room (e.g., a kitchen) must be available to perform the task. The occupational therapist can use this list to determine if the spaces, tools, and materials that he or she has available (or could make available) are sufficient to allow for the inclusion of the task on his or her global AMPS task option list. Again, it is important to remember to *include, at this stage, as many tasks as possible on the global AMPS task option list*. There will be opportunities later in this process to consider more deeply the relevance of the tasks for the occupational therapist’s client population and omit tasks that would never be relevant to any of the persons in the occupational therapist’s client population.

When making this long list of possible tasks, the occupational therapist must keep in mind that *contriving AMPS task performances is not acceptable*. *Contriving AMPS tasks invalidates the results of the AMPS* because the tasks are not performed in a standardized (and naturalistic) manner. Therefore, the occupational therapist must make a realistic appraisal of the match between (a) the spaces available (including how they are equipped); and (b) the spaces, tools, and materials needed to perform the ADL tasks. Compare the following examples:

Jeremy planned on using the AMPS with his clients. One task he considered was loading and starting a washing machine. Jeremy did not have access to a washing machine at his clinic. While he considered the idea of using a large cardboard box as a washing machine, he realized this would mean inordinately contriving the task environment — using a box as a washing machine. Contriving task performances in this manner is not acceptable.

Victoria also planned on administering AMPS observations with her clients. She also identified that loading and starting a washing machine was a possible task option for inclusion on her global task option list. Although Victoria did have access to a washing machine, it was a small washing machine that only accommodates a small amount of laundry. Victoria reasoned that she could still administer an AMPS observation using this machine. This did not inordinately contrive the task because the person would still use a washing machine for its intended purpose — to wash clothes.

4.3.1 Identifying Possible AMPS Tasks Given the Spaces Available

In the following sections we look more closely at what AMPS tasks can be used in different testing spaces — ranging from rooms with tables and chairs to the client’s own home. In Section 4.3.2 we discuss the importance of having available the appropriate tools and materials. At this point in the process of developing a global AMPS task option list, the occupational therapist needs only to keep in mind the possibilities he or she has for ensuring that needed tools and materials could be available. For example:

Alicia has a small kitchen area in her clinic, but the clinic kitchen does not have a toaster or a coffee maker. Alicia reasoned, however, that she could request her clinic to purchase these items. Alicia, therefore, tentatively included tasks that involved the use of a toaster or coffee maker on her global AMPS task option list.

AMPS Task Options in Rooms with Only Tables and Chairs

The worst case scenario is having only a room with tables and chairs or some other space with limited furnishings. Certainly this is less than ideal if we are to

meet the needs of our clients and implement client-centered practice. But, even with a simple room, we still have some possibilities for assessing our clients. If the only space available is a room with tables and chairs (e.g., activity room, classroom), a review of the tasks listed in Volume 2, Chapter 3, AMPS Task Descriptions, will yield several task choice options. Most of them, however, are average or easier on the AMPS process task challenge hierarchy. (For more information on ensuring that tasks present an adequate challenge to the person being tested, see Chapter 5, Section 5.2.3.) The tasks that readily can be carried out in such settings are:

- Hot or cold instant beverage (Task A-2)
- Sweeping the floor (Task J-1)
- Vacuuming (Tasks J-3 and J-4)
- Cleaning windows (Task J-8)
- Folding a basket of laundry (Task L-1)
- Ironing a shirt (Tasks L-4 and L-5)
- Polishing shoes (Task O-1)
- Eating a meal (Task P-1)
- Putting on socks and shoes (Tasks P-4 and P-5)
- Upper body dressing — garment within reach (Task P-6)
- Eating a snack with a utensil (Task P-12)
- Eating a snack and drinking a beverage (Task P-13)

Other tasks, such as those that require a sink for water or cupboards for storage, or cooking tasks that require a refrigerator, would have to be inordinately contrived if the person were to perform them in a room that has only tables and chairs.

AMPS Task Options in Rooms with Tables, Chairs, Sinks, Cupboards, and Drawers

Having access to a sink, cupboards, and drawers expands the list of possible task choices, although the available task options remain average or easier on the AMPS process task challenge hierarchy. (For more information on ensuring tasks present an adequate challenge to the person being tested, see Chapter 5, Section 5.2.3.) In addition to the tasks listed above, the following tasks become options in this environment:

- Mopping the floor (Task J-5)
- Hand washing dishes, drying and putting away dishes (Task J-9)
- Hand washing laundry (Task L-2)
- Setting a table (Tasks M-1 and M-2)
- Repotting a small houseplant (Task N-1)
- Watering plants and removing dead leaves (Task N-2)

If there are cupboards, but no drawers, setting the table would not be an appropriate task option as there would be no natural place to store the knives, forks, and spoons. Again, because most of the food preparation tasks require a refrigerator, they also would not be appropriate options in a room that has only tables, chairs, a sink, cupboards, and drawers.

If the client has a pet dog or cat, and can be observed in the place where the pet lives, the following tasks are also options for this environment:

- Feeding a cat — dry cat food and water (Task S-1)
- Feeding a cat — moist cat food and water (Task S-2)
- Feeding a dog — dry dog food and water (Task S-3)
- Feeding a dog — moist dog food and water (Task S-4)

AMPS Task Options in Hospital or Nursing Home Rooms

Many of the tasks suggested above also can be administered in the person's hospital or nursing home room. In addition to those tasks, other tasks appropriate for a hospital or nursing home room include:

- Making a bed (Tasks K-1, K-2, K-3, and K-7)
- Changing sheets on a bed (Tasks K-4, K-5, and K-6)
- Self-care tasks (Tasks P-2, P-3, P-7 through P-9, and P-14 through P-16)

To facilitate evaluating people in hospital or nursing home rooms, the occupational therapist can ensure that he or she has available a basket of laundry and supplies for polishing shoes that he or she can easily carry from an occupational therapy clinic to the person's room. Brooms and vacuums used by the housekeeping staff often are available for use during an AMPS observation. Laundry can be hand

washed in the person's bathroom. A person may also be observed making his or her bed. Finally, all of the PADL tasks were designed so that they could be observed in hospital or nursing home rooms — at bedside or at a sink. While all of these tasks are average or easier on the AMPS process task challenge hierarchy, this typically is not a problem as persons who must be seen in their rooms are generally more frail. (For more information on ensuring tasks present an adequate challenge to the person being tested, see Chapter 5, Section 5.2.3.)

Outdoor AMPS Task Options

By considering tasks that can be done outdoors, a few tasks that are average or harder than average on the AMPS process task challenge hierarchy become available options for more able persons who do not cook and/or for the occupational therapist who has no access to a kitchen. (For more information on ensuring tasks present an adequate challenge to the person being tested, see Chapter 5, Section 5.2.3.) Nursing homes often have small garden areas that can be used for the weeding task. All hospitals and nursing homes have outdoor spaces that can be swept, and many may have leaves or grass to rake. If the person has a car, he or she may need to clean the inside of the car. Shopping may be an option. The shopping task may also be performed in hospital gift shops. The tasks that can be performed outdoors include:

- Sweeping outside (Task Q-1)
- Raking grass cuttings or leaves (Task Q-2)
- Weeding (Q-3)
- Vacuuming the inside of an automobile (Task Q-4)
- Shopping (Task R-1)

AMPS Task Options for Home Environments

The home is the ideal context for administering the AMPS. The person's home will be equipped with the tools and materials that he or she usually uses and will usually provide a large number of task options. In his or her home, the person should be able to perform any AMPS task that would be appropriate to his or her level of ability, needs, and priorities. Bringing some food items such as cans of soup, cans of tuna, bread, some eggs, celery, onions, etc. can help overcome resistance to participating in an AMPS observation caused by a person's concern about using his or her own food

supplies. A telephone call a day or two ahead of the scheduled AMPS observation can help the occupational therapist clarify what extra tools and materials may need to be brought into the person's home. Having these supplies can also make it possible to ensure that the person is offered task choices that provide an appropriate challenge. Remember that all of the outdoor tasks are appropriate options for those persons living in houses with yards, small garden areas, patios, garages, and so on.

4.3.2 Identifying Possible AMPS Tasks Given the Available Tools and Materials

As discussed earlier, the occupational therapist should also use Volume 2, Chapter 3, AMPS Task Descriptions, to ensure that he or she has the required tools and materials available for each task that may be an option given the spaces available. Again, the occupational therapist should not rely on the task title to make this decision. Many tasks have required tools and materials that may not be evident from the task name. For example:

When Evelyn read the title for Task F-1, Peanut butter and jelly sandwich, she assumed she could not use that task with her clients as it was “an American task.” When she read the AMPS Task Description in Volume 2, Chapter 3, she realized that Task F-1 actually could be a task that is relevant to her client population as they could substitute chocolate-flavored hazelnut cream or some other similar spread for the peanut butter, as long as they also used butter or some other soft spread.

Juan has a kitchen in his clinic. Initially, when he read the title for Task A-1, Beverage from the refrigerator, he thought it would be an appropriate task to include on his global AMPS task option list. But, after reading the task description, and noting that the beverage container should contain approximately 1 liter (30 oz) of liquid, Juan determined that he would not be able to have the required materials on hand to ensure that this task would be performed according to the task criteria. That is, Juan's clinic provides individual juice containers (holding approximately 250 ml or 8 oz of juice) that his clients may choose to drink at any time. His clinic has disallowed the use of larger containers of juice or other beverages, including pitchers of water. Therefore, he omitted Task A-1 from the global AMPS task option list he was preparing.

Because the clinic kitchen where Alicia works currently does not have a toaster or a coffee maker (although she had requested her clinic to purchase them), Alicia decided to temporarily eliminate those tasks that require the use of a toaster or coffee maker from her global AMPS task option list. She will add those tasks back on her global AMPS task option list as soon as she receives the toaster and coffee maker and learns how to operate them.

The occupational therapist must read the AMPS Task Descriptions in Volume 2, Chapter 3 before determining if a task can be included or eliminated from his or her global AMPS task option list. In doing so, the occupational therapist may find that some tasks he or she assumed were relevant will need to be omitted, while other tasks that the occupational therapist planned to omit can and should be retained.

4.4 Step 4: Determining Relevant AMPS Task Options for a Client Population

Keeping in mind what the occupational therapist has considered regarding (a) the spaces, tools, and materials the occupational therapist has available; and (b) all possible AMPS tasks that can be done in the available spaces, the occupational therapist should continue to refer to Volume 2, Chapter 3, AMPS Task Descriptions, and ask the following questions:

- Which of all the possible AMPS tasks that can be performed in my testing environment, given the available tools and materials, might, at least occasionally, be relevant for use with the people I will evaluate?
 - What AMPS tasks are relevant to my clients' living environments and/or cultural backgrounds?
 - What do my clients need and want to do?

The answers to these questions will help the occupational therapist identify the full range of tasks that will be relevant and, therefore, possible to use in AMPS observations with his or her client population.

Referring to the global AMPS task option list he or she has been creating, the occupational therapist should now omit any tasks from consideration that no one in his or her range of clients would (a) know how to perform, (b) need to perform, or (c) perform due to their living situation or their cultural background. In other words, *the occupational therapist should only omit those tasks for which he or she would never have clients for which the task would be relevant.*

To ensure client-centered practice, it is crucial that the occupational therapist retain all tasks on the global AMPS task option list that may be options for his or her client population.

Because the AMPS is designed as an international assessment, there are many AMPS tasks that are tailored for persons from specific cultures. For example, Task I-2, Fried green plantains (“tostones”) was developed for persons living in Central and South America. It is probably safe to assume that a person born and raised in Japan would be unfamiliar with this task. This task could, therefore, be eliminated as a possible option from a global AMPS task option list created by an occupational therapist living in Japan. If, however, the occupational therapist treats clients from particular cultural backgrounds, and there are AMPS tasks that may be relevant for them, those tasks should remain as possible options provided they can be performed in the spaces available. For example:

Karin works with clients in hospice settings in Sweden. These clients rarely leave the home, but many still are interested in remaining as independent as possible with self-care and light meal preparation tasks. Therefore, after reading the task descriptions, Karin omitted all AMPS tasks that had to be performed outside the home as they were not relevant to the clients’ living situations. Karin also

eliminated all AMPS tasks that would not be relevant to the cultural background of her clients. Considering that the majority of her clients are Swedish, and all of her clients come from Nordic countries, she omitted tasks that were clearly tailored to other cultures. For example, she omitted:

- *Spanish omelette with added ingredients (D-7)*
- *Peanut butter and jelly sandwich (Task F-1)*
- *Fried green plantains (“tostones”) (Task I-2)*
- *Fried ripe plantains (Task I-3)*
- *Fried meat and vegetable dish with a bowl of rice (Task I-10)*
- *Fried rice (Task I-11)*
- *Miso soup (Task I-21)*
- *Rice, soup, and a side dish (Task I-22)*
- *Spreading bedding on the floor, Japanese style (Task K-8)*
- *Eating an Asian meal with chopsticks (Task P-9)*

Karin also noticed that there were quite a few tasks that were tailored specifically for persons with a Scandinavian background. She included all of those tasks on her global AMPS task option list.

4.5 Step 5: Ensuring Familiarity with the Global AMPS Task Option List

Finally, the range of possible AMPS tasks included on the global AMPS task option list should be ones that the occupational therapist knows how to perform. Moreover, ***the occupational therapist should be familiar with the variety of ways a task logically can be performed in order to evaluate the person’s performance.*** For example:

Anita, an occupational therapist working in the southern part of Sweden, observed a person make boiled coffee as part of an AMPS observation. Anita, however, had never seen a person make boiled coffee before. She was aware that people who make boiled coffee put the coffee grounds in water and boil

them, but little more. She, therefore, did not know whether or not to penalize a person for performing the task using the following sequence: (a) putting ground coffee and water in a kettle, (b) placing the kettle on the stove, (c) heating it and bringing the coffee to a boil, (d) removing the kettle from the burner on the stove, (e) pouring some of the coffee into a cup, and then (f) pouring the coffee from the cup back into the kettle, and repeating this last step two or three times.

To Anita, this sequence of actions, especially pouring the coffee back and forth between the cup and the kettle several times, seemed rather unusual, but when she talked with some of her colleagues from Northern Sweden, she learned that the process the person had used would be viewed as logical by anyone living in Northern Sweden. More importantly, Anita's implementation of an AMPS evaluation without knowing how to perform the task resulted in her inability to score the quality of the person's performance. Anita now realized, because she really had no idea how to perform a task involving the preparation of boiled coffee, she should have omitted all such tasks from her global AMPS task option list until she had learned more about the variety of ways one can make boiled coffee.

Hopefully the tasks that are possible to perform in the available testing environments, for which the needed tools and materials are available, and that are of priority to the occupational therapist's client population, are also tasks that the occupational therapist knows how to perform. As in Anita's case, however, there may be AMPS tasks that are relevant to the occupational therapist's clients, but which the occupational therapist does not know how to perform. In this case, ***in order to maintain a client-centered evaluation process, the occupational therapist should learn how to perform those tasks which are relevant to his or her clients, but which he or she does not know how to perform, before adding them to the global AMPS task option list, and before using them to evaluate clients.*** For example:

Amelia works in a community wellness program with older adults within a large metropolitan city. This city has a very diverse population and Amelia works with persons from various backgrounds, but particularly with persons originating from Spain. Amelia knew that Task D-7, Spanish omelette with added ingredients, would be relevant to many of her clients. Amelia, however,

did not know how to perform this task. She decided, therefore, to learn how to make a Spanish omelette. She did this by talking with some of her colleagues and clients and asking them to explain how they performed the task. She then had one of them demonstrate how she performed the task. Once Amelia became familiar with the variety of ways to make a Spanish omelette, she included this task on her global AMPS task option list and began to include it among the task options for her clients.

4.6 Step 6: Addressing Concerns Regarding the Appropriateness of the AMPS for a Client Population

After the occupational therapist has learned more about the AMPS in relation to his or her work spaces and the needs and interests of his or her client population, the occupational therapist should reflect on the following questions:

- From what I know about the AMPS so far, am I concerned that I have clients who have problems with ADL, but who I might not be able to assess using the AMPS?
 - Do I have clients who I feel are not appropriate to evaluate using the AMPS?
 - Do I work with older, frail adults in nursing homes who no longer perform IADL tasks?
 - Do I work with persons whose caregivers do most of their ADL tasks for them?
 - Am I concerned that ADL tasks are not relevant for my male clients?
 - Do I work with persons with severe developmental disabilities or young children who have never performed ADL tasks?

As we suggested earlier, if the person who seeks or was referred to occupational therapy has a need or desire to perform ADL tasks, and he or she currently has problems performing needed or desired ADL tasks, there is a reason to consider administering the AMPS. ***There are two restrictions, however, to the administration of the AMPS. First, the person must be willing or have a need*** (including a need based on societal

expectations, especially among those who “lack motivation” to perform expected tasks) *to perform, even if only at a marginal level, simple ADL tasks.*

Persons who have no need or desire to perform ADL tasks are not appropriate candidates for an AMPS evaluation. For example, cultural norms (e.g., expectations pertaining to the care of the elderly or persons with disabilities) may influence the client’s need to perform ADL. A person may (a) expect to be taken care of, and (b) have members of his or her client constellation willing to provide that care. We must be aware of this and respect the impact of culture for our clients. In another example, it would be unethical and unwise to “insist” or “force” a person who initially seems to “lack motivation” or who “refuses” to perform needed ADL tasks. In this instance, the occupational therapist must first develop therapeutic rapport and a trusting relationship in which the person feels “safe,” motivated, and/or willing to perform needed ADL tasks (see Chapter 13, Section 13.1).

In our experience, however, few clients actually have no need or desire to perform at least simple ADL tasks. A critical consideration here is that we are speaking about clients who seek or were referred to occupational therapy. We assume, therefore, that the client has goals related to some aspect of occupational performance. For example, while persons in *nursing homes* may be restricted in what tasks they are allowed to perform, many continue to perform PADL tasks and wish to remain active, and some plan to return to their homes. Even persons with caregivers usually need or want to perform at least some ADL tasks. Also, in our experience, *gender* is rarely an issue when performing ADL tasks. Each AMPS task has been performed at least 35% of the time by men, and many of the tasks have been performed 50% to 80% of the time by men (see Chapter 15, Section 15.3.4). Finally, we often find that many clients who seem to “*lack motivation*,” or who express *no needs* related to ADL tasks, actually do have concerns and interests in improving their performance of ADL tasks if we take the time needed to establish therapeutic rapport and conduct a thorough occupational therapy interview.

The second restriction involves the client’s familiarity with ADL tasks. Because the person must be familiar with the tasks that he or she is observed performing, the person should have had experience with at least two of the tasks included in Volume 2, Chapter 3, AMPS Task Descriptions. For this reason, very young children (under 2 years) are not appropriate candidates for an AMPS observation. Other persons who may fall into this category are low functioning persons with severe

developmental disabilities. While developing or improving occupational performance may be a goal of intervention, it can be difficult to evaluate a person who has had no prior experience performing any of the tasks listed in Volume 2, Chapter 3. This does not mean, however, that the AMPS will always be an inappropriate evaluation tool for these persons. Persons without experience must be given the opportunity to become familiar with and even practice relevant AMPS tasks prior to initiating an AMPS observation. Special considerations for administering the AMPS to persons with no experience performing AMPS tasks is presented in Chapter 13.

4.7 Case Example – AMPS Initial Preparation

Step 1: Committing to Using the AMPS

Alexa is an occupational therapist working for a private home health agency in the United States. This means that Alexa travels to her clients' homes and provides occupational therapy services there. Alexa was considering using the AMPS in her practice. She reflected on the broad range of clients that she serves and noted that the vast majority of her clients identify problems with ADL including self-care, home maintenance, and cooking. In fact, the majority of Alexa's clients are referred to occupational therapy due to problems performing these types of tasks. Alexa made a commitment to use the AMPS to evaluate the majority of her clients.

Step 2: Considering Available Spaces for Administering the AMPS

Because Alexa works within the client's home, she usually has access to kitchens, bedrooms, bathrooms, and other home areas. These homes usually have the common tools and materials required to perform routine PADL and IADL tasks. Sometimes her clients have outdoor spaces in which they would like to perform tasks. Alexa reasoned that she would have access to many natural, task-relevant spaces, equipped with relevant tools and materials, in which to administer AMPS observations.

Step 3: Identifying Possible AMPS Task Options Given the Available Spaces, Tools, and Materials

Alexa was now ready to begin creating her global AMPS task option list — a list of all possible AMPS tasks that could be performed in the spaces she has available. She began to consider what tasks could be performed in the spaces in which her clients live. Alexa read Volume 2, Chapter 3, AMPS Task Descriptions, and realized that she would be able to use almost all of the AMPS tasks within her clients' homes. While she was tempted to remove tasks she guessed her clients might never perform, she recalled that this step would come later in her reasoning process. She, therefore, initially kept all AMPS tasks on her list.

As Alexa then began to reflect on the available tools and materials required to perform AMPS tasks, she was aware that most of her clients have homes with adequate tools and materials to perform a variety of home maintenance and meal preparation tasks. Alexa knew that some of her clients, although a smaller number, would even have more specialized tools like woks, rice cookers, and espresso makers. Alexa, therefore, continued to keep all AMPS tasks on her global AMPS task option list.

Alexa was concerned that some of her clients may not be willing to use their own food for an occupational therapy evaluation. Alexa also knew that, due to economic reasons, some of her clients' households would not have enough supplies to make even a simple sandwich. Alexa reasoned that she would need to have some supplies ready in order to facilitate an AMPS observation. Alexa planned on having a small box in her car with a variety of non- and semi-perishable foods. She would also need a small cooler to carry items such as milk or eggs, which are more perishable.

Step 4: Determining Relevant AMPS Task Options for a Client Population

Keeping in mind (a) her clients' range of problems with ADL; (b) the spaces, tools, and materials available; as well as (c) the AMPS tasks that could be performed in her clients' home, Alexa used Volume 2, Chapter 3, AMPS Task Descriptions, to narrow down her global AMPS task option list by asking herself three questions. First, she asked "What is the range of AMPS tasks that I can

use?” *Second, she asked, “What AMPS tasks are relevant to my clients’ living environments and/or cultural backgrounds?”*

As Alexa read the task descriptions found in Volume 2, Chapter 3, she noticed that there were some tasks that seemed to be tailored to people of different cultural backgrounds. Given that none of her clients identified with Nordic cultures, Alexa reasoned that her clients would very likely never perform certain Nordic culture-specific tasks and omitted these tasks from her global AMPS task option list:

- *Hot cooked cereal, open-face cheese sandwich, and beverage (Task C-4)*
- *Open-face cheese or liverpaste sandwich on unsliced soft bread and boiled/brewed coffee or tea (Task F-5)*
- *Open face cheese or liverpaste sandwich on presliced bread and boiled/brewed coffee or tea (Task F-6)*
- *Open-face meat or cheese sandwich with sliced vegetable (Task F-7)*
- *Open-face sandwich with soft spread and sliced vegetable (Task F-8)*
- *Meatballs with boiled potatoes, sauce, boiled vegetable, and beverage (Task I-19)*
- *Making a bed against a wall, “duvet” edges folded under (Task K-2)*
- *Making a freestanding bed, “duvet” edges folded under (Task K-3)*

Although they are few, Alexa occasionally does see clients with backgrounds from Asia and Central and South America. She decided, therefore, that she would keep the following tasks:

- *Fried green plantains (“tostones”) (Task I-2)*
- *Fried ripe plantains (Task I-3)*
- *Fried rice (Task I-11)*
- *Miso soup (Task I-21)*
- *Rice, soup, and a side dish (Task I-22)*
- *Spreading bedding on the floor, Japanese style (Task K-8)*
- *Eating an Asian meal with chopsticks (Task P-9)*

The third question Alexa asked herself was, “What do my clients need and want to do?” Alexa reflected on the range of her clients’ interests and priorities and her list of possible AMPS tasks. She knew that her clients had needs and desires to perform tasks ranging from basic PADL to more complex IADL, including meal preparation. She wondered if any needed or wanted to vacuum their car, wash windows, or rake leaves, but kept those tasks and others like them on her global AMPS task option list in the event that she had a client who expressed an interest or need to perform them. She felt that it was better to keep too many tasks on her list versus omitting tasks of potential use. In fact, given the wide range of interests and abilities within her client population, Alexa decided to keep all of the rest of the AMPS tasks on her global AMPS task option list. She was pleased that she had such a large range of tasks with which to use when administering the AMPS. She felt that this would ensure that her assessments would be client-centered.

Step 5: Ensuring Familiarity with the Global AMPS Task Option List

As Alexa read the task descriptions of the tasks that were possible options for her clients, she made sure that she knew how to perform each of the tasks. She was concerned that she was not very familiar with polishing shoes, given that she did not normally perform this task. She decided to have a family member teach her how to polish shoes so that she could be able to identify a variety of appropriate ways to complete this task. Alexa was also aware that she did not know how to perform the two tasks involving the use of plantains (Tasks I-2 and I-3), and that she would need to learn how to perform them before offering them as task choices to her clients.

Step 6: Addressing Concerns Regarding the Appropriateness of the AMPS for a Client Population

Alexa was concerned about whether she could administer the AMPS to a smaller portion of her clients who rely heavily on caregivers to complete all of their ADL tasks. Many of these clients, however, want to remain or become more independent in some portion of their ADL tasks, so Alexa believed that these clients may still benefit from an AMPS observation. For those clients who express no desire to decrease their dependence on caregiver assistance,

Alexa reasoned that she would probably not administer an AMPS observation as she advocates for client-centered practice. She would, however, consider the need for occupational therapy services related to caregiver training. For these clients, Alexa decided that she would make her decision once she met and interviewed them.

