

Appendix F  
Interview Guide- Family Caregiver

**Participant #:** \_\_\_\_\_ **Conducted By:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

Hi \_\_\_\_\_. It's nice to meet you! Thank you for letting me come to your home today. '

Several weeks ago I spoke to you over the phone about the research study I am conducting. I am looking at the assistive devices and tools that are being used in the community by older adults with dementia and their family caregivers, like yourself! Do you know what an assistive device is?

Well, assistive devices can help individuals to compensate for impairments or difficulties arising from the cognitive changes that occur with dementia. These devices can also be used to help caregivers provide support to their loved ones. We are defining an assistive device as any item, product or piece of equipment that can support an individual perform daily occupations that they would not otherwise be able to do as a result of dementia-related impairments, or that increases the ease and safety with which occupations can be performed.

Assistive devices and tools can be thought of as anything from calendar clocks and memory books, to reminder systems and automatic lighting.

Do you have any questions for me so far?

Before we begin, I would like to go over the study details with you so that you are aware of your rights as a research participant. (*Go over consent forms- if informed consent is obtained, continue*).

I am going to start the interview now. If there is a question you do not understand, let me know and I will repeat the question or if there is a question you don't feel comfortable answering, we can skip over it. If you have any questions or comments during the interview don't hesitate to ask me at any time. I would just like to make sure it's OK that I will be taking pictures of some of the assistive devices that you or your loved one uses and that I will be audio-recording interview. Is this alright with you?

**[If participant declines to be audio-recorded] OK, I understand. I will still ask you all the same questions and will write down your answers instead. Is this alright with you?**

**Part 1 – Background Information**

To begin, I would first like to learn a bit more about you.

**1. What age category do you fit into?**

- <40 years
- 40-49 years
- 50-59 years
- 60-69 years
- 70-79 years
- 80+ years

**2. Gender:** \_\_\_\_\_ (this will be filled in by interviewer, not asked)

**3. What is the highest level of education you have obtained?**

- Some High School
- High School
- Some College/University
- Completed College/University
- Post Graduate Studies
- Other \_\_\_\_\_

**4. What is your relationship to your family member with dementia?**

- Spouse
- Daughter
- Son
- Granddaughter/Son
- Daughter-in-Law
- Son-in-Law
- Other \_\_\_\_\_

**5. Approximately how much time do you spend with him/her each day?**

Hours/Day: \_\_\_\_\_

**6. Is your loved one:**  Male  Female

**7. What age category does your loved one fit into?**

- <40 years
- 40-49 years
- 50-59 years
- 60-69 years
- 70-79 years
- 80+ years

**8. When was your loved one diagnosed with dementia?**

Date (or number of years): \_\_\_\_\_

**9. I would like to get an idea of your familiarity and comfort level with technology.**

- a. Do you use a radio Yes No
- b. Do you use a television Yes No
- i. [If Yes] – Do you have cable/satellite TV? Yes No
- ii. [If Yes] – Do you have a VCR/DVD player Yes No
- c. Do you use a computer? Yes No
- d. Do you use a cell phone? Yes No
- e. Do you drive a car? Yes No
- i. [If Yes] – Do you use a GPS system in your car? Yes No

f. On a scale of 1 to 5 please rate how comfortable you are using or trying some sort of technology?

1                      2                      3                      4                      5

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- 1 = Not comfortable at all
- 2 = Not very comfortable
- 3 = Neutral
- 4 = Somewhat comfortable
- 5 = Very comfortable

**10. I would like to get a sense of your loved one’s level of functioning. Please answer by saying ‘yes’ or ‘no’ to the following statements and provide any comments or examples as necessary.**

Impairment	YES	NO	COMMENTS/EXAMPLES
a) <b>Problems with memory</b> – can’t remember new things (STM) and can’t remember past (LTM)			
b) <b>Disorientation</b> – to person, place or time disorientation; visual spatial disorientation, inability to interpret environmental cues			
c) <b>Personality changes</b> – irritability, poor temper control, anxiety, inflexibility, inappropriate mood or behaviour, flat affect, withdrawal from social interaction, decreased ability to function in social interactions			
d) <b>Communication difficulties</b> – absent or impaired language abilities, difficulty with word finding and expressing needs, etc.			

**Part 2 – Identifying and Describing Assistive Devices Used**

I am now going to ask you some questions about various categories of devices you or your loved one may use to help with day- to-day life. For each device that you do use, I am going to ask you some follow-up questions.

**i. ORIENTATION DEVICES**

Participant #: \_\_\_\_\_

Do you or your loved one use any **orientation devices to help support orientation to person, place or time?** These devices that help prompt the date and time for individuals who have difficulty orienting themselves.

**-IF NO/UNSURE:** Orientation devices can be items such as wall clock calendars, electronic calendars, day timers or reminder clocks that are used to provide information about the time or place.

**-If YES:**

What is the name of this orientation device? \_\_\_\_\_

*(If many assistive devices are named for this category, ask for the most commonly used for category and continue with follow up questions)*

- a) Who uses this **orientation device**?  
\_\_\_ Myself      \_\_\_ My loved one      \_\_\_ Both of us
- b) Who would you say is the primary user? (If **you** use an orientation device, please only consider your use if it is to help with care giving role and not if it is for your own day-to-day use.)  
\_\_\_ Myself      \_\_\_ My loved one

Can you describe/show me how it is used?

*(Proceed with Caregiver questions or Care Recipient Questions where applicable)*

### **CAREGIVER QUESTIONS**

*If it is to help with care giving-* What care giving activity do you use this device with?

- b) How frequently do you use this orientation device to help with care giving?

1                      2                      3                      4                      5

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- 1 – Less than once a month  
2 – Once a month  
3- Once a week  
4- Two to three times a week  
5- Daily

-For how long have you been using it?

-Has your use changed over time? If so, how?

- c) How helpful do you find this **orientation device**?

1                      2                      3                      4                      5

---

- 1 –Very unhelpful  
2- Unhelpful  
3- Neutral  
4- Helpful  
5- Very helpful

-Is there anything you like about this **orientation device**? What?

-Is there anything that makes it easy to use? What?

Participant #: \_\_\_\_\_

-Is there anything you do not like about this **orientation device**? What?  
-Is there anything that makes it difficult to use?

d) How comfortable are you using this **orientation device**?

1                      2                      3                      4                      5  
\_\_\_\_\_

1. Very Uncomfortable
2. Uncomfortable
3. Neutral
4. Comfortable
5. Very Comfortable

-Can you explain your reasons for choosing this response?

### CARE RECIPIENT QUESTIONS

For this set of questions, I would like you to think about your loved one's use of the **orientation device**. Please try to answer the best you can while considering his/her perspective.

-Have you ever seen your loved one use this **orientation device** on his/her own?

e) How frequently does your loved one use this **orientation device**?

1                      2                      3                      4                      5  
\_\_\_\_\_

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week
- 4- Two to three times a week
- 5- Daily

-For how long has your loved one been using this **orientation device** to help with any cognitive difficulties?

-Has your loved one's/your use changed over time? If so, how?

f) How helpful would you say this **orientation device** is for your loved one?

1                      2                      3                      4                      5  
\_\_\_\_\_

- 1 –Very Unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful
- 5- Very Helpful

-Is there anything your loved one likes about this **orientation device**? What?

- Is there anything that makes this device easy to use for your loved one? What?
- Is there anything your loved one does not like about this **orientation device**? What?
- Is there anything that makes this device difficult to use for your loved one? What?

g) How comfortable is your loved one using this **orientation device**?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

-Can you explain your reasons for choosing this response?

-How did you hear about this **orientation device**?

- |   |  |
|---|--|
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Internet      |
| <input type="checkbox"/> Physical Therapist     | <input type="checkbox"/> Saw in store  |
| <input type="checkbox"/> Social Worker          | <input type="checkbox"/> Advertisement |
| <input type="checkbox"/> Physician              | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Friend                 |  |
| <input type="checkbox"/> Family Member          |  |

-How was this **orientation device** paid for?

- Assistive Device Program
- You purchased it
- Other government funding
- Gift
- You already had it lying around the home
- Other \_\_\_\_\_

**IF NO (Does not use this category of device):**

-What are the reasons for you and your loved one NOT using an **orientation device**?

You can choose more than one of the following responses.

- Haven't heard of it
- Does not apply to my care giving role
- Does not apply to loved one
- Too expensive
- Too complicated/too hard to learn
- Not available
- Not interested
- Other \_\_\_\_\_

-How useful do these **orientation devices** sound to you?

-If one of these **orientation devices** was given to you or your loved one, would you use it?

-Why/why not?

**ii. MEDICATION REMINDERS**

Do you or your loved one use any **medication reminders** to provide support for medication management? These devices help people who have difficulty remembering to take their medication at the correct time. IF NO/UNSURE: For example, medication reminders may include pill boxes, automatic pill reminders or automatic pill dispensers)

**-If YES:**

What is the name of the medication reminder you use?

*(If many assistive devices are named for this category, ask for the most commonly used for category and continue with follow up questions)*

- a) Who uses this **medication reminder**?  
\_\_\_ Myself      \_\_\_ My loved one      \_\_\_ Both of us
- b) Who would you say is the primary user? (If **you** use medication reminder, please only consider your use if it is to help with care giving role and not if it is for your own day-to-day use.)  
\_\_\_ Myself      \_\_\_ My loved one

Can you describe/show me how it is used?

*(Proceed with Caregiver questions and/or Care Recipient Questions where applicable)*

**CAREGIVER QUESTIONS**

*If it is to help with care giving-* What care giving activity do you use this device for?

- g) How frequently do you use this **medication reminder** to help with care giving?

1                      2                      3                      4                      5

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week
- 4- Two to three times a week
- 5- Daily

-For how long have you been using it?

-Has your use changed over time? If so, how?

- h) How helpful do you find this **medication reminder**?

1                      2                      3                      4                      5

- 1 –Very unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful

Participant #: \_\_\_\_\_

5- Very helpful

- Is there anything you like about this **medication reminder**? What?
- Is there anything that makes it easy to use? What?
- Is there anything you do not like about this **medication reminder**? What?
- Is there anything that makes it difficult to use?

i) How comfortable are you using this **medication reminder**?

1                      2                      3                      4                      5

---

- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

-Can you explain your reasons for choosing this response?

**CARE RECIPIENT QUESTIONS**

For this set of questions, I would like you to think about your loved one's use of the medication reminder. Please try to answer the best you can while considering their perspective.

-Have you ever seen your loved one use the **medication reminder** on his/her own?

j) How frequently does your loved one use this **medication reminder**?

1                      2                      3                      4                      5

---

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week
- 4- Two to three times a week
- 5- Daily

-For how long has your loved one been using this **medication reminder** to help with any cognitive difficulties?

-Has your loved one's/your use changed over time? If so, how?

k) How helpful would you say this **medication reminder** is for your loved one?

1                      2                      3                      4                      5

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- 1 –Very Unhelpful
- 2- Unhelpful
- 3- Neutral

- 4- Helpful
- 5- Very Helpful

- Is there anything your loved one likes about this **medication reminder**? What?
- Is there anything that makes it easy to use for your loved one? What?
- Is there anything your loved one does not like about this **medication reminder**? What?
- Is there anything that makes it difficult to use for your loved one? What?

h) How comfortable is your loved one using this **medication reminder**?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

-Can you explain your reasons for choosing this response?

-How did you hear about this **medication reminder**?

- Occupational Therapist
- Physical Therapist
- Social Worker
- Physician
- Friend
- Family Member
- Internet
- Saw in store
- Advertisement
- Other \_\_\_\_\_

-How was this **medication reminder** paid for?

- Assistive Device Program
- You purchased it
- Other government funding
- Gift
- You already had it lying around the home
- Other \_\_\_\_\_

**IF NO (Does not use this category of device):**

-What are the reasons for you and your loved one NOT using a **medication reminder**? You can choose more than one of the following responses.

- Haven't heard of it
- Does not apply to my care giving role
- Does not apply to loved one
- Too expensive
- Too complicated/too hard to learn
- Not available
- Not interested

Participant #: \_\_\_\_\_

- \_\_\_\_\_ Other \_\_\_\_\_
- How useful do **medication reminders** sound to you?
  - If one of these **medication reminders** was given to you or your loved one, would you use it?
  - Why/why not?

**iii. REMINDER SYSTEMS (or Memo Minders)**

Does your loved one use, or have you provided your loved one with **memo minders or reminder systems**? This group of devices help people who have difficulty remembering to carry out tasks and/or remembering to stop a task. **IF NO/UNSURE:** This is a large category of devices. For example, auto shut off kettles or stove minders fall under this category, as do devices that play a short recorded message that can give prompts and reminders. More sophisticated memo minders can play messages when movement is detected (for example, if placed by the front door can it remind person to lock the door or to not leave the building). Do you use anything that sounds like this?

**-If YES:**

What is the name of the device you use? \_\_\_\_\_  
*(If many assistive devices are named for this category, ask the most commonly used in category and continue with follow up questions)*

- a) Who uses this **reminder system**?  
 \_\_\_\_\_ Myself      \_\_\_\_\_ My loved one      \_\_\_\_\_ Both of us
- b) Who would you say is the primary user? (If **you** use a reminder system, please only consider your use if it is to help with care giving role and not if it is for your own day-to-day use.)  
 \_\_\_\_\_ Myself      \_\_\_\_\_ My loved one

Can you describe/show me how it is used?  
*(Proceed with Caregiver questions or Care Recipient Questions where applicable)*

**CAREGIVER QUESTIONS**

*If it is to help with care giving-* What care giving activity do you use this device for?

b) How frequently do you use this **reminder system** to help with care giving?

1                      2                      3                      4                      5

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week
- 4- Two to three times a week
- 5- Daily

- For how long have you been using it?
- Has your use changed over time? If so, how?

c) How helpful do you find this **reminder system**?

1                      2                      3                      4                      5

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- 1 –Very unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful
- 5- Very helpful

- Is there anything you like about this **reminder system**? What?
- Is there anything that makes it easy to use? What?
- Is there anything you do not like about this **reminder system**? What?
- Is there anything that makes it difficult to use?

d) How comfortable are you using this **reminder system**?

1                      2                      3                      4                      5

---

- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

- Can you explain your reasons for choosing this response?

### **CARE RECIPIENT QUESTIONS**

For the next set of questions, I would like you to think about your loved one's use of the **reminder system**. Please try to answer the best you can while considering their perspective.

- Have you ever seen your loved one use the **reminder system** on his/her own?

e) How frequently does your loved one use this **reminder system**?

1                      2                      3                      4                      5

---

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week
- 4- Two to three times a week
- 5- Daily

- For how long has your loved one been using this **reminder system** to help compensate for any cognitive difficulties?

-Has your loved one's/your use changed over time? If so, how?

f) How helpful would you say this **reminder system** is for your loved one?

1                      2                      3                      4                      5

---

- 1 –Very Unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful
- 5- Very Helpful

-Is there anything your loved one likes about this **reminder system**? What?

-Is there anything that makes it easy to use for your loved one? What?

-Is there anything your loved one does not like about this **reminder system**? What?

-Is there anything that makes it difficult to use for your loved one? What?

g) How comfortable is your loved one using this **reminder system**?

1                      2                      3                      4                      5

---

- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

-Can you explain your reasons for choosing this response?

-How did you hear about this **reminder system**?

Occupational Therapist

Physical Therapist

Social Worker

Physician

Friend

Family Member

Internet

Saw in store

Advertisement

Other \_\_\_\_\_

-How was this **reminder system** paid for?

Assistive Device Program

You purchased it

Other government funding

Gift

You already had it lying around the home

Other \_\_\_\_\_

**IF NO (Does not use this category of device):**

Participant #: \_\_\_\_\_

-What are the reasons for you and your loved one NOT using a **reminder system**?  
You can choose more than one of the following responses.

- Haven't heard of it
- Does not apply to my care giving role
- Does not apply to loved one
- Too expensive
- Too complicated/too hard to learn
- Not available
- Not interested
- Other \_\_\_\_\_

-How useful do **reminder systems** sound to you?

-If one of these **reminder systems** was given to you or your loved one, would you use it?

-Why/why not?

#### iv. **SIGNS, NOTICES and OTHER ENVIRONMENTAL AIDS**

Do you or your loved one use **signs or notices** around your home – these are simple visual aids that can help remind people to do things. **IF NO/UNSURE:** For example, signs, labels, whiteboards, bulletin boards, and pictures throughout your home can be used to trigger your loved one's memory.

#### **If YES:**

What is the name of the device you use? \_\_\_\_\_

*(If many assistive devices are named for this category, ask the most commonly used in category and continue with follow up questions)*

a) Who uses these **environmental aids**?

Myself       My loved one       Both of us

a) Who would you say is the primary user? (If **you** use an environmental aid, please only consider your use if it is to help with care giving role and not if it is for your own day-to-day use.)

Myself       My loved one

Can you describe/show me how it is used?

*(Proceed with Caregiver questions and/or Care Recipient Questions where applicable)*

#### **CAREGIVER QUESTIONS**

*If it is to help with care giving-* What care giving activity do you use this **environmental aid** for?

b) How frequently do you use this type of **environmental aid** to help with care giving?

1                      2                      3                      4                      5

1 – Less than once a month

2 – Once a month

3- Once a week

Participant #: \_\_\_\_\_

- 4- Two to three times a week
- 5- Daily

-For how long have you been using it?  
-Has your use changed over time? If so, how?

c) How helpful do you find this type of **environmental aid**?

1                      2                      3                      4                      5

---

- 1 –Very unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful
- 5- Very helpful

-Is there anything you like about this type of **environmental aid**? What?  
-Is there anything that makes it easy to use? What?  
-Is there anything you do not like about this **environmental aid**? What?  
-Is there anything that makes it difficult to use?

d) How comfortable are you using this **environmental aid**?

1                      2                      3                      4                      5

---

- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

-Can you explain your reasons for choosing this response?

### CARE RECIPIENT QUESTIONS

For the next set of questions, I would like you to think about your loved one's use of the **environmental aid**. Please try to answer the best you can while considering their perspective.

-Have you ever seen your loved one use the **environmental aid** on his/her own?

e) How frequently does your loved one use this **environmental aid**?

1                      2                      3                      4                      5

---

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week

- 4- Two to three times a week
- 5- Daily

-For how long has your loved one been using this **environmental aid** to help compensate for any cognitive difficulties?  
 -Has your loved one's/your use changed over time? If so, how?

f) How helpful would you say this **environmental aid** is for your loved one?

1                      2                      3                      4                      5

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- 1 -Very Unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful
- 5- Very Helpful

-Is there anything your loved one likes about this **environmental aid**? What?  
 -Is there anything that makes it easy to use for your loved one? What?  
 -Is there anything your loved one does not like about this **environmental aid**? What?  
 -Is there anything that makes it difficult to use for your loved one? What?

g) How comfortable is your loved one using this **environmental aid**?

1                      2                      3                      4                      5

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- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

-Can you explain your reasons for choosing this response?

-How did you hear about this device?

- Occupational Therapist
- Physical Therapist
- Social Worker
- Physician
- Friend
- Family Member
- Internet
- Saw in store
- Advertisement
- Other \_\_\_\_\_

-How was this **environmental aid** paid for?

- Assistive Device Program
- You purchased it
- Other government funding

- Gift
- You already had it lying around the home
- Other \_\_\_\_\_

**IF NO (Does not use this category of device):**

-What are the reasons for you and your loved one NOT using a sign or notice to help prompt memory? You can choose more than one of the following responses.

- Haven't heard of it
- Does not apply to my care giving role
- Does not apply to loved one
- Too expensive
- Too complicated/too hard to learn
- Not available
- Not interested
- Other \_\_\_\_\_

-How useful do these **environmental aids** sound to you?

-If one of these **environmental aids** was given to you or your loved one, would you use it?

-Why/why not?

**v. PHONE or PHONE with MODIFICATIONS**

Does your loved use a **phone or phone with modifications**, so that your he/she can communicate with family members when not in the same room or building?

**IF NO/UNSURE:** This can include regular telephones, cordless phones and cell phones and modifications of phones can include a bigger screen, large buttons and programmable numbers.

**If YES:**

What type of phone does your loved one use?

What modifications have you incorporated into this phone, if any?

*(Note all modifications used)*

Does your loved one have any difficulty using the phone and if so, what are these difficulties?

Can you describe/show me how it is used?

*(N.B. For this category of devices, proceed with Care Recipient Questions where applicable)*

**CARE RECIPIENT QUESTIONS**

For this set of questions, I would like you to think about your loved one's use of the **phone/phone with modifications**. Please try to answer the best you can while considering their perspective.

-Have you ever seen your loved one use this device on his/her own?

e) How frequently does your loved one use the **phone**?

1                      2                      3                      4                      5

---

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week
- 4- Two to three times a week
- 5- Daily

-For how long has your loved one been using this **phone/phone with modifications** to help compensate for any cognitive difficulties?

-Has your loved one's/your use changed over time? If so, how?

f) How helpful would you say this **phone/phone with modifications** is for your loved one?

1                      2                      3                      4                      5

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- 1 –Very Unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful
- 5- Very Helpful

-Is there anything your loved one likes about this **phone/phone with modifications**? What?

-Is there anything that makes it easy to use for your loved one? What?

-Is there anything your loved one does not like about this **phone/phone with modifications**? What?

-Is there anything that makes it difficult to use for your loved one? What?

g) How comfortable is your loved one using this **phone/phone with modifications**?

1                      2                      3                      4                      5

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- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

-Can you explain your reasons for choosing this response?

-How did you hear about this **phone/phone with modifications**?

\_\_\_ Occupational Therapist

\_\_\_ Social Worker

\_\_\_ Physical Therapist

\_\_\_ Internet

\_\_\_ Physician

\_\_\_ Saw in store

Participant #: \_\_\_\_\_

Friend  
 Family Member

Advertisement  
 Other \_\_\_\_\_

-How was this **phone/phone with modifications** paid for?

Assistive Device Program  
 You purchased it  
 Other government funding  
 Gift  
 You already had it lying around the home  
 Other \_\_\_\_\_

**IF NO (Does not use this category of device):**

-What are the reasons for your loved one NOT using a phone with modifications, a cell phone, etc.? You can choose more than one of the following responses.

Haven't heard of it  
 Does not apply to my care giving role  
 Does not apply to loved one  
 Too expensive  
 Too complicated/too hard to learn  
 Not available  
 Not interested  
 Other \_\_\_\_\_

-How useful would a **phone/phone with modifications** be for your loved one ?

-If one of these **phones/phone with modifications** was given to you or your loved one, would you use it?

-Why/why not?

**vi. ALARM or PAGER UNITS**

Do you or your loved one use any **alarm or pager units**? These devices alert a caregiver or community monitoring center if your loved one needs help. **IF**

**NO/UNSURE:** Lifeline is a common example a community alarm. Another example is an individual system that is linked to a relative through their mobile phone.

**If YES:**

What is the name of the device you use? \_\_\_\_\_

*(If many assistive devices are named for this category, ask the most commonly used in category and continue with follow up questions)*

a) Who uses this **alarm or pager unit**?

Myself       My loved one       Both of us

b) Who would you say is the primary user? (If **you** use an alarm or pager unit, please only consider your use if it is to help with care giving role and not if it is for your own day-to-day use.)

Myself       My loved one

Can you describe/show me how it is used?

*(Proceed with Caregiver questions or Care Recipient Questions where applicable)*

### CAREGIVER QUESTIONS

*If it is to help with care giving-* What care giving activity do you use this device for?

b) How frequently do you use this **alarm/pager unit** to help with care giving?

1                      2                      3                      4                      5

---

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week
- 4- Two to three times a week
- 5- Daily

-For how long have you been using it?

-Has your use changed over time? If so, how?

c) How helpful do you find this **alarm/pager unit**?

1                      2                      3                      4                      5

---

- 1 –Very unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful
- 5- Very helpful

-Is there anything you like about this **alarm/pager unit**? What?

-Is there anything that makes it easy to use? What?

-Is there anything you do not like about this **alarm/pager unit**? What?

-Is there anything that makes it difficult to use?

d) How comfortable are you using this **alarm/pager unit**?

1                      2                      3                      4                      5

---

- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

-Can you explain your reasons for choosing this response?

### CARE RECIPIENT QUESTIONS

For this next set of questions, I would like you to think about your loved one's use of the **alarm or pager unit**. Please try to answer the best you can while considering their perspective.

Participant #: \_\_\_\_\_

-Have you ever seen your loved one use this **alarm/pager unit** on his/her own?

e) How frequently does your loved one use this **alarm/pager unit**?

1                      2                      3                      4                      5

---

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week
- 4- Two to three times a week
- 5- Daily

-For how long has your loved one been using this **alarm/pager unit** to help compensate for any cognitive difficulties?

-Has your loved one's/your use changed over time? If so, how?

f) How helpful would you say this **alarm/pager unit** is for your loved one?

1                      2                      3                      4                      5

---

- 1 –Very Unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful
- 5- Very Helpful

-Is there anything your loved one likes about this **alarm/pager unit**? What?

-Is there anything that makes it easy to use for your loved one? What?

-Is there anything your loved one does not like about this **alarm/pager unit**? What?

-Is there anything that makes it difficult to use for your loved one? What?

g) How comfortable is your loved one using this **alarm/pager unit**?

1                      2                      3                      4                      5

---

- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

-Can you explain your reasons for choosing this response?

-How did you hear about this **alarm/pager unit**?

\_\_\_ Occupational Therapist

\_\_\_ Physical Therapist

Participant #: \_\_\_\_\_

- Social Worker
- Physician
- Friend
- Family Member

- Internet
- Saw in store
- Advertisement
- Other \_\_\_\_\_

- How was this **alarm/pager unit** paid for?
- Assistive Device Program
  - You purchased it
  - Other government funding
  - Gift
  - You already had it lying around the home
  - Other \_\_\_\_\_

**IF NO (Does not use this category of device):**

-What are the reasons for you and your loved one NOT using an **alarm or pager unit**? You can choose more than one of the following responses.

- Haven't heard of it
- Does not apply to my care giving role
- Does not apply to loved one
- Too expensive
- Too complicated/too hard to learn
- Not available
- Not interested
- Other \_\_\_\_\_

-How useful do these **alarm/pager units** sound to you?

-If one of these **alarms/pager units** was given to you or your loved one, would you use it?

-Why/why not?

**vii. FALL DETECTORS**

Does your loved one use, or have you installed in your home, **fall detectors** – these detect if a person is getting out of bed, rising from a chair, or if they have fallen.

**IF NO/UNSURE:** For example pressure sensors or mats on can be put on beds, floor or chairs that detect if an individual has risen or fallen.

**If YES:**

What is the name of the **fall detector** you use?

*(If many assistive devices are named for this category, ask the most commonly used in category and continue with follow up questions)*

a) Who uses this **fall detectors**?

Myself       My loved one       Both of us

b) Who would you say is the primary user? (If **you** use a fall detector, please only consider your use if it is to help with care giving role and not if it is for your own day-to-day use.)

Myself       My loved one

Can you describe/show me how it is used?

*(Proceed with Caregiver questions or Care Recipient Questions where applicable)*

### **CAREGIVER QUESTIONS**

*If it is to help with care giving-* What care giving activity do you use this device for?

b) How frequently do you use this device to help with care giving?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

1 – Less than once a month

2 – Once a month

3- Once a week

4- Two to three times a week

5- Daily

-For how long have you been using it?

-Has your use changed over time? If so, how?

c) How helpful do you find this device?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

1 –Very unhelpful

2- Unhelpful

3- Neutral

4- Helpful

5- Very helpful

-Is there anything you like about this **fall detector**? What?

-Is there anything that makes it easy to use? What?

-Is there anything you do not like about this **fall detector**? What?

-Is there anything that makes it difficult to use?

d) How comfortable are you using this **fall detector**?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

1. Very Uncomfortable

2. Uncomfortable

3. Neutral

4. Comfortable

5. Very Comfortable

-Can you explain your reasons for choosing this response?

### **CARE RECIPIENT QUESTIONS**

For this set of questions, I would like you to think about your loved one's use of the **fall**

Participant #: \_\_\_\_\_

**detector.** Please try to answer the best you can while considering their perspective.

-Have you ever seen your loved one use this **fall detector** on his/her own?

e) How frequently does your loved one use this **fall detector**?

1                      2                      3                      4                      5

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week
- 4- Two to three times a week
- 5- Daily

-For how long has your loved one been using this **fall detector** to help compensate for any cognitive difficulties?

-Has your loved one's/your use changed over time? If so, how?

f) How helpful would you say this **fall detector** is for your loved one?

1                      2                      3                      4                      5

- 1 –Very Unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful
- 5- Very Helpful

-Is there anything your loved one likes about this **fall detector**? What?

-Is there anything that makes it easy to use for your loved one? What?

-Is there anything your loved one does not like about this **fall detector**? What?

-Is there anything that makes it difficult to use for your loved one? What?

g) How comfortable is your loved one using this **fall detector**?

1                      2                      3                      4                      5

- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

-Can you explain your reasons for choosing this response?

-How did you hear about this **fall detector**?

\_\_\_ Occupational Therapist

\_\_\_ Social Worker

Participant #: \_\_\_\_\_

- Physical Therapist
- Physician
- Friend
- Family Member

- Internet
- Saw in store
- Advertisement
- Other \_\_\_\_\_

-How was this **fall detector** paid for?

- Assistive Device Program
- You purchased it
- Other government funding
- Gift
- You already had it lying around the home
- Other \_\_\_\_\_

**IF NO (Does not use this category of device):**

-What are the reasons for you and your loved one NOT using a **fall detector**? You can choose more than one of the following responses.

- Haven't heard of it
- Does not apply to my care giving role
- Does not apply to loved one
- Too expensive
- Too complicated/too hard to learn
- Not available
- Not interested
- Other \_\_\_\_\_

-How useful do these **fall detectors** sound to you?

-If one of these **fall detectors** was given to you or your loved one, would you use it?

-Why/why not?

**viii. ENVIRONMENTAL DETECTORS/MANIPULATORS**

Do you or your loved one use any **environmental detectors/manipulators** in your home? These devices detect environmental changes and can either alter the environment or alert the caregiver or monitoring centre that the sensor has been triggered.

**IF NO/UNSURE:**

For example an environmental detector/manipulator can include: extreme water temperature monitor or gas detectors.

**If YES:**

What is the name of the **environmental detector/manipulator** you use?

*(If many assistive devices are named for this category, ask the most commonly used in category and continue with follow up questions)*

- a) Who uses this **environmental detector/manipulator**?  
 Myself       My loved one       Both of us
- b) Who would you say is the primary user? (If **you** use an environmental detector/manipulator, please only consider your use if it is to help with care giving role and not if it is for your own day-to-day use.)

\_\_\_ Myself      \_\_\_ My loved one

Can you describe/show me how it is used?

*(Proceed with Caregiver questions and/or Care Recipient Questions where applicable)*

### **CAREGIVER QUESTIONS**

*If it is to help with care giving-* What care giving activity do you use this device for?

b) How frequently do you use this **environmental detector** to help with care giving?

1                      2                      3                      4                      5

---

1 – Less than once a month

2 – Once a month

3- Once a week

4- Two to three times a week

5- Daily

-For how long have you been using it?

-Has your use changed over time? If so, how?

c) How helpful do you find this **environmental detector**?

1                      2                      3                      4                      5

---

1 –Very unhelpful

2- Unhelpful

3- Neutral

4- Helpful

5- Very helpful

-Is there anything you like about this **environmental detector**? What?

-Is there anything that makes it easy to use? What?

-Is there anything you do not like about this **environmental detector**? What?

-Is there anything that makes it difficult to use?

d) How comfortable are you using this **environmental detector**?

1                      2                      3                      4                      5

---

1. Very Uncomfortable

2. Uncomfortable

3. Neutral

4. Comfortable

5. Very Comfortable

-Can you explain your reasons for choosing this response?

Participant #: \_\_\_\_\_



-Can you explain your reasons for choosing this response?

-How did you hear about this **environmental detector**?

- |   |  |
|---|--|
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Physical Therapist     | <input type="checkbox"/> Internet      |
| <input type="checkbox"/> Physician              | <input type="checkbox"/> Saw in store  |
| <input type="checkbox"/> Friend                 | <input type="checkbox"/> Advertisement |
| <input type="checkbox"/> Family Member          | <input type="checkbox"/> Other _____   |

-How was this **environmental detector** paid for?

- Assistive Device Program
- You purchased it
- Other government funding
- Gift
- You already had it lying around the home
- Other \_\_\_\_\_

**IF NO (Does not use this category of device):**

-What are the reasons for you and your loved one NOT using any **environmental detectors**? You can choose more than one of the following responses.

- Haven't heard of it
- Does not apply to my care giving role
- Does not apply to loved one
- Too expensive
- Too complicated/too hard to learn
- Not available
- Not interested
- Other \_\_\_\_\_

-How useful do these **environmental detectors** sound to you?

-If one of these **environmental detectors** was given to you or your loved one, would you use it?

-Why/why not?

#### ix. **“WANDERING” TECHNOLOGIES**

Do you use anything which can be used to detect if your loved one is wandering from home?

**IF NO/UNSURE:** For example, a door alarm or other sensors that alert if an individual has wandered.

**If YES:**

What is the name of the device you use? \_\_\_\_\_

*(If many assistive devices are named for this category, ask the most commonly used in category and continue with follow up questions)*

a) Who uses this **“wandering” technology**?

Myself       My loved one       Both of us

b) Who would you say is the primary user? (If **you** use this “wandering” detector,

please only consider your use if it is to help with care giving role and not if it is for your own day-to-day use.)

\_\_\_ Myself      \_\_\_ My loved one

Can you describe/show me how it is used?

*(Proceed with Caregiver questions or Care Recipient Questions where applicable)*

### **CAREGIVER QUESTIONS**

*If it is to help with care giving-* What care giving activity do you use this device for?

b) How frequently do you use this **“wandering” technology** to help with care giving?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

1 – Less than once a month

2 – Once a month

3- Once a week

4- Two to three times a week

5- Daily

-For how long have you been using it?

-Has your use changed over time? If so, how?

c) How helpful do you find this **“wandering” technology**?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

1 –Very unhelpful

2- Unhelpful

3- Neutral

4- Helpful

5- Very helpful

-Is there anything you like about this **“wandering” technology**? What?

-Is there anything that makes it easy to use? What?

-Is there anything you do not like about this **“wandering” technology**? What?

-Is there anything that makes it difficult to use?

d) How comfortable are you using this **“wandering” technology**?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

1. Very Uncomfortable

2. Uncomfortable

3. Neutral

4. Comfortable

5. Very Comfortable

Participant #: \_\_\_\_\_

-Can you explain your reasons for choosing this response?

### CARE RECIPIENT QUESTIONS

For this set of questions, I would like you to think about your loved one's use of this **"wandering" technology**. Please try to answer the best you can while considering their perspective.

-Have you ever seen your loved one use this device on his/her own?

e) How frequently does your loved one use this **"wandering" technology**?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week
- 4- Two to three times a week
- 5- Daily

-For how long has your loved one been using this **"wandering" technology** to help compensate for any cognitive difficulties?

-Has your loved one's/your use changed over time? If so, how?

f) How helpful would you say this **"wandering" technology** is for your loved one?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

- 1 –Very Unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful
- 5- Very Helpful

-Is there anything your loved one likes about this **"wandering" technology**? What?

-Is there anything that makes it easy to use for your loved one? What?

-Is there anything your loved one does not like about this **"wandering" technology**? What?

-Is there anything that makes it difficult to use for your loved one? What?

g) How comfortable is your loved one using this **"wandering" technology**?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable

Participant #: \_\_\_\_\_

5. Very Comfortable

-Can you explain your reasons for choosing this response?

-How did you hear about this “wandering” technology?

- |   |  |
|---|--|
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Physical Therapist     | <input type="checkbox"/> Internet      |
| <input type="checkbox"/> Physician              | <input type="checkbox"/> Saw in store  |
| <input type="checkbox"/> Friend                 | <input type="checkbox"/> Advertisement |
| <input type="checkbox"/> Family Member          | <input type="checkbox"/> Other _____   |

-How was this “wandering” technology paid for?

- Assistive Device Program
- You purchased it
- Other government funding
- Gift
- You already had it lying around the home
- Other \_\_\_\_\_

**IF NO (Does not use this category of device):**

-What are the reasons for you and your loved one NOT using any wandering detectors? You can choose more than one of the following responses.

- Haven't heard of it
- Does not apply to my care giving role
- Does not apply to loved one
- Too expensive
- Too complicated/too hard to learn
- Not available
- Not interested
- Other \_\_\_\_\_

-How useful do these “wandering” detectors sound to you?

-If one of these “wandering” detectors was given to you or your loved one, would you use it?

-Why/why not?

**x. TV, MUSIC, RADIO and COMPUTER AIDS**

Does your loved one use any of the following:

- a) TV
- b) Radio
- c) Music Player
- d) Computer

If YES - Do you or your loved one use any aids or modifications to help enhance his/her use of these appliances?

**IF NO/UNSURE:** For example, modifications include: easy to see and use TV remote controls; or accessible computer software and electronic games.

**If YES:**

What is the name of the modifications you use?

*(If many assistive devices are named for this category, ask the most commonly used in category and continue with follow up questions)*

- a) Who uses this aid or modification?  
\_\_\_ Myself      \_\_\_ My loved one      \_\_\_ Both of us
- b) Who would you say is the primary user? (If **you** use an aid or modification, please only consider your use if it is to help with care giving role and not if it is for your own day-to-day use.)  
\_\_\_ Myself      \_\_\_ My loved one

Can you describe/show me how it is used?

*(Proceed with Caregiver questions or Care Recipient Questions where applicable)*

### **CAREGIVER QUESTIONS**

*If it is to help with care giving-* What care giving activity do you use this device for?

b) How frequently do you use this **modification/aid** to help with care giving?

1                      2                      3                      4                      5

---

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week
- 4- Two to three times a week
- 5- Daily

-For how long have you been using it?

-Has your use changed over time? If so, how?

c) How helpful do you find this **modification/aid**?

1                      2                      3                      4                      5

---

- 1 –Very unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful
- 5- Very helpful

-Is there anything you like about this **modification/aid**? What?

-Is there anything that makes it easy to use? What?

-Is there anything you do not like about this **modification/aid**? What?

-Is there anything that makes it difficult to use?

d) How comfortable are you using this **modification/aid**?

Participant #: \_\_\_\_\_

1                      2                      3                      4                      5

---

1. Very Uncomfortable
2. Uncomfortable
3. Neutral
4. Comfortable
5. Very Comfortable

-Can you explain your reasons for choosing this response?

### **CARE RECIPIENT QUESTIONS**

For this set of questions, I would like you to think about your loved one's use of the **aid or modification**. Please try to answer the best you can while considering their perspective.

-Have you ever seen your loved one use this **aid or modification** on his/her own?

e) How frequently does your loved one use this **aid or modification**?

1                      2                      3                      4                      5

---

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week
- 4- Two to three times a week
- 5- Daily

-For how long has your loved one been using this **aid/modification** to help compensate for any cognitive difficulties?

-Has your loved one's/your use changed over time? If so, how?

f) How helpful would you say this **aid/modification** is for your loved one?

1                      2                      3                      4                      5

---

- 1 –Very Unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful
- 5- Very Helpful

-Is there anything your loved one likes about this **aid/modification**? What?

-Is there anything that makes it easy to use for your loved one? What?

-Is there anything your loved one does not like about this **aid/modification**? What?

-Is there anything that makes it difficult to use for your loved one? What?

g) How comfortable is your loved one using this **aid/modification**?

1                      2                      3                      4                      5

---

1. Very Uncomfortable
2. Uncomfortable
3. Neutral
4. Comfortable
5. Very Comfortable

-Can you explain your reasons for choosing this response?

-How did you hear about this device?

- |   |  |
|---|--|
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Physical Therapist     | <input type="checkbox"/> Internet      |
| <input type="checkbox"/> Physician              | <input type="checkbox"/> Saw in store  |
| <input type="checkbox"/> Friend                 | <input type="checkbox"/> Advertisement |
| <input type="checkbox"/> Family Member          | <input type="checkbox"/> Other _____   |

-How was this **aid/modification** paid for?

- Assistive Device Program
- You purchased it
- Other government funding
- Gift
- You already had it lying around the home
- Other \_\_\_\_\_

**IF NO (Does not use this category of device):**

-What are the reasons for you and your loved one NOT using any **aids or modifications** for TVs, music players or computers? You can choose more than one of the following responses.

- Haven't heard of it
- Does not apply to my care giving role
- Does not apply to loved one
- Too expensive
- Too complicated/too hard to learn
- Not available
- Not interested
- Other \_\_\_\_\_

-How useful do these **aids or modifications** sound to you?

-If one of these **aids or modifications** was given to you or your loved one, would you use it?

-Why/why not?

**Part 3 – Identifying Occupational Performance**

Now I would like to focus on your loved one's occupations or daily activities. I have a

Participant #: \_\_\_\_\_

list here for you that describes various everyday activities that your loved one may or may not have difficulty with (See Appendix G). I will give you a few moments to look it over and then I will ask you some questions.

i. I would like you to **first identify one important activity that is the most difficult for your loved one to perform.**

Activity: \_\_\_\_\_

Do you or your loved one use any tools or devices to help with \_\_\_\_\_, in order to do it with more ease and/or to increase his/her safety?

**If YES:**

What is the name of the device you use? \_\_\_\_\_

*(If many assistive devices are named for this category, ask the most commonly used in category and continue with follow up questions)*

a) Who uses this device?

\_\_\_ Myself      \_\_\_ My loved one      \_\_\_ Both of us

b) Who would you say is the primary user? (If **you** use this device, please only consider your use if it is to help with care giving role and not if it is for your own day-to-day use.)

\_\_\_ Myself      \_\_\_ My loved one

Can you describe/show me how it is used?

*(Proceed with Caregiver questions or Care Recipient Questions where applicable)*

**CAREGIVER QUESTIONS**

*If it is to help with care giving-* What care giving activity do you use this device for?

b) How frequently do you use this device to help with care giving?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

□1 – Less than once a month

2 – Once a month

3- Once a week

4- Two to three times a week

5- Daily

-For how long have you been using it?

-Has your use changed over time? If so, how?

c) How helpful do you find this device?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

1 –Very unhelpful

2- Unhelpful

Participant #: \_\_\_\_\_

- 3- Neutral
- 4- Helpful
- 5- Very helpful

- Is there anything you like about this device? What?
- Is there anything that makes it easy to use? What?
- Is there anything you do not like about this device? What?
- Is there anything that makes it difficult to use?

d) How comfortable are you using this device?

1                      2                      3                      4                      5

---

- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

-Can you explain your reasons for choosing this response?

### CARE RECIPIENT QUESTIONS

For this set of questions, I would like you to think about your loved one's use of the device. Please try to answer the best you can while considering their perspective.

-Have you ever seen your loved one use this device on his/her own?

e) How frequently does your loved one use this device?

1                      2                      3                      4                      5

---

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week
- 4- Two to three times a week
- 5- Daily

-For how long has your loved one been using this device to help compensate for any cognitive difficulties?

-Has your loved one's/your use changed over time? If so, how?

f) How helpful would you say this device is for your loved one?

1                      2                      3                      4                      5

---

- 1 –Very Unhelpful
- 2- Unhelpful

- 3- Neutral
- 4- Helpful
- 5- Very Helpful

- Is there anything your loved one likes about this device? What?
- Is there anything that makes it easy to use for your loved one? What?
- Is there anything your loved one does not like about this device? What?
- Is there anything that makes it difficult to use for your loved one? What?

g) How comfortable is your loved one using this device?

1                      2                      3                      4                      5

---

- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

-Can you explain your reasons for choosing this response?

-How did you hear about this device?

- |   |  |
|---|--|
| <input type="checkbox"/> Occupational Therapist<br><input type="checkbox"/> Physical Therapist<br><input type="checkbox"/> Physician<br><input type="checkbox"/> Friend<br><input type="checkbox"/> Family Member | <input type="checkbox"/> Social Worker<br><input type="checkbox"/> Internet<br><input type="checkbox"/> Saw in store<br><input type="checkbox"/> Advertisement<br><input type="checkbox"/> Other _____ |
|---|--|

-How was this device paid for?

- Assistive Device Program
- You purchased it
- Other government funding
- Gift
- You already had it lying around the home
- Other \_\_\_\_\_

**IF NO (Does not use this category of device):**

-What are the reasons for you and your loved one NOT using any device to help with this activity? You can choose more than one of the following responses.

- Haven't heard of anything
- Does not apply to my care giving role
- Does not apply to loved one
- Too expensive
- Too complicated/too hard to learn
- Not available
- Not interested

\_\_\_\_\_ Other \_\_\_\_\_

-Do you think it would be useful for you or your loved one to have something to help with \_\_\_\_\_ activity?

-If one of you or your loved one was given a device to help with this activity, would you use it?

-Why/why not?

ii. Looking over this list again, I would like you to identify **one activity that you, as a caregiver, are having the most difficulty with providing support to your loved one.**

Activity: \_\_\_\_\_

Do you use any tools or devices to help provide support for your loved one while doing \_\_\_\_\_ (activity).

**If YES:**

What is the name of the device you use? \_\_\_\_\_

*(If many assistive devices are named for this category, ask the most commonly used in category and continue with follow up questions)*

a) Who uses this device?

\_\_\_\_ Myself      \_\_\_\_ My loved one      \_\_\_\_ Both of us

b) Who would you say is the primary user? (If **you** use this device, please only consider your use if it is to help with care giving role and not if it is for your own day-to-day use.)

\_\_\_\_ Myself      \_\_\_\_ My loved one

Can you describe/show me how it is used?

*(Proceed with Caregiver questions and/or Care Recipient Questions where applicable)*

### **CAREGIVER QUESTIONS**

*If it is to help with care giving-* What care giving activity do you use this device for?

b) How frequently do you use this device to help with care giving?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

1 – Less than once a month

2 – Once a month

3- Once a week

4- Two to three times a week

5- Daily

-For how long have you been using it?

-Has your use changed over time? If so, how?

c) How helpful do you find this device?

Participant #: \_\_\_\_\_

1                      2                      3                      4                      5

---

- 1 –Very unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful
- 5- Very helpful

- Is there anything you like about this device? What?
- Is there anything that makes it easy to use? What?
- Is there anything you do not like about this device? What?
- Is there anything that makes it difficult to use?

d) How comfortable are you using this device?

1                      2                      3                      4                      5

---

- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

- Can you explain your reasons for choosing this response?

### **CARE RECIPIENT QUESTIONS**

For this set of questions, I would like you to think about your loved one's use of the device. Please try to answer the best you can while considering their perspective.

- Have you ever seen your loved one use this device on his/her own?

e) How frequently does your loved one use this device?

1                      2                      3                      4                      5

---

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week
- 4- Two to three times a week
- 5- Daily

- For how long has your loved one been using this device to help compensate for any cognitive difficulties?
- Has your loved one's/your use changed over time? If so, how?

f) How helpful would you say this device is for your loved one?

1                      2                      3                      4                      5

---

- 1 –Very Unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful
- 5- Very Helpful

- Is there anything your loved one likes about this device? What?
- Is there anything that makes it easy to use for your loved one? What?
- Is there anything your loved one does not like about this device? What?
- Is there anything that makes it difficult to use for your loved one? What?

g) How comfortable is your loved one using this device?

1                      2                      3                      4                      5

---

- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

-Can you explain your reasons for choosing this response?

-How did you hear about this device?

- |   |  |
|---|--|
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Physical Therapist     | <input type="checkbox"/> Internet      |
| <input type="checkbox"/> Physician              | <input type="checkbox"/> Saw in store  |
| <input type="checkbox"/> Friend                 | <input type="checkbox"/> Advertisement |
| <input type="checkbox"/> Family Member          | <input type="checkbox"/> Other _____   |

-How was this device paid for?

- Assistive Device Program
- You purchased it
- Other government funding
- Gift
- You already had it lying around the home
- Other \_\_\_\_\_

**IF NO (Does not use this category of device):**

-What are the reasons for you and your loved one NOT using any devices to help with this activity? You can choose more than one of the following responses.

- Haven't heard of anything
- Does not apply to my care giving role
- Does not apply to loved one

Participant #: \_\_\_\_\_

- \_\_\_ Too expensive
- \_\_\_ Too complicated/too hard to learn
- \_\_\_ Not available
- \_\_\_ Not interested
- \_\_\_ Other \_\_\_\_\_

-Do you think it would be useful you or your loved one to have something to help with \_\_\_\_\_ activity?

-If one of these devices was given to you or your loved one, would you use it?  
-Why/why not?

iii. Looking over the list one last time, please **identify one activity that your loved one is performing successfully either independently or with minimal assistance.**

Do you or your loved one use any tool or device to help perform \_\_\_\_\_ activity with more ease and/or to increase safety during this activity?

**If YES:**

What is the name of the device you use? \_\_\_\_\_

*(If many assistive devices are named for this category, ask the most commonly used in category and continue with follow up questions)*

- a) Who uses this device?  
 \_\_\_ Myself      \_\_\_ My loved one      \_\_\_ Both of us
- b) Who would you say is the primary user? (If **you** use this device, please only consider your use if it is to help with care giving role and not if it is for your own day-to-day use.)  
 \_\_\_ Myself      \_\_\_ My loved one

Can you describe/show me how it is used?

*(Proceed with Caregiver questions and/or Care Recipient Questions where applicable)*

**CAREGIVER QUESTIONS**

*If it is to help with care giving-* What care giving activity do you use this device for?

b) How frequently do you use this device to help with care giving?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week
- 4- Two to three times a week
- 5- Daily

-For how long have you been using it?  
-Has your use changed over time? If so, how?

c) How helpful do you find this device?

1                      2                      3                      4                      5

---

- 1 –Very unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful
- 5- Very helpful

- Is there anything you like about this device? What?
- Is there anything that makes it easy to use? What?
- Is there anything you do not like about this device? What?
- Is there anything that makes it difficult to use?

d) How comfortable are you using this device?

1                      2                      3                      4                      5

---

- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

- Can you explain your reasons for choosing this response?

### **CARE RECIPIENT QUESTIONS**

For this set of questions, I would like you to think about your loved one's use of the device. Please try to answer the best you can while considering their perspective.

- Have you ever seen your loved one use this device on his/her own?

e) How frequently does your loved one use this device?

1                      2                      3                      4                      5

---

- 1 – Less than once a month
- 2 – Once a month
- 3- Once a week
- 4- Two to three times a week
- 5- Daily

- For how long has your loved one been using this device to help compensate for any cognitive difficulties?
- Has your loved one's/your use changed over time? If so, how?

f) How helpful would you say this device is for your loved one?

1                      2                      3                      4                      5

---

- 1 –Very Unhelpful
- 2- Unhelpful
- 3- Neutral
- 4- Helpful
- 5- Very Helpful

- Is there anything your loved one likes about this device? What?
- Is there anything that makes it easy to use for your loved one? What?
- Is there anything your loved one does not like about this device? What?
- Is there anything that makes it difficult to use for your loved one? What?

g) How comfortable is your loved one using this device?

1                      2                      3                      4                      5

---

- 1. Very Uncomfortable
- 2. Uncomfortable
- 3. Neutral
- 4. Comfortable
- 5. Very Comfortable

-Can you explain your reasons for choosing this response?

-How did you hear about this device?

- |   |  |
|---|--|
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Physical Therapist     | <input type="checkbox"/> Internet      |
| <input type="checkbox"/> Physician              | <input type="checkbox"/> Saw in store  |
| <input type="checkbox"/> Friend                 | <input type="checkbox"/> Advertisement |
| <input type="checkbox"/> Family Member          | <input type="checkbox"/> Other _____   |

-How was this device paid for?

- Assistive Device Program
- You purchased it
- Other government funding
- Gift
- You already had it lying around the home
- Other \_\_\_\_\_

**IF NO (Does not use this category of device):**

-What are the reasons for you and your loved one NOT using any devices to help with this activity? You can choose more than one of the following responses.

- Haven't heard of anything
- Does not apply to my care giving role

Participant #: \_\_\_\_\_

- \_\_\_\_\_ Does not apply to loved one
- \_\_\_\_\_ Too expensive
- \_\_\_\_\_ Too complicated/too hard to learn
- \_\_\_\_\_ Not available
- \_\_\_\_\_ Not interested
- \_\_\_\_\_ Other \_\_\_\_\_

-Do you think it would useful you or your loved one to have something to help with \_\_\_\_\_ activity?

-If one of these devices was given to you or your loved one, would you use it?  
-Why/why not?

#### **Part 4 – Identifying Unmet Needs**

We are now nearing the end of the interview. So far we have discussed what devices you use in care giving and what devices your loved one use to help with daily activities and to increase safety throughout the home. I would like to learn more about what you wish existed or what you need help with.

I would like you to think of an activity you or your loved one has to carry out that has been the most impacted by dementia, that you feel is a challenge or that you feel you have little or no support for. What is this?

Now I want you to take a minute to imagine that you have been offered the opportunity to have an assistive device made just for you and your loved one. You have all the resources in the world – money is no problem, you have a team of expert designers and builders at your disposal and there absolutely no constraints on practicality or time.

- What would this device be able to do to help you or your loved one with the problem you mentioned above?

Is there anything you want to share with me about assistive technology?

That concludes the interview! Do you have any questions for me?

Thank you very much for allowing me to come to your home today and for showing me the devices that you and your family member use. I will send you the results of the study if you wish – would you like that? (If YES- Would you like the study results mailed or emailed to you?) If you have any questions in the meantime, please feel free to contact me.

