ACTIVITIES OF DAILY LIVING (ADL/IADL) DEFICITS

BEHAVIORAL DEFINITIONS

1. Decline in ability to accomplish one or more basic Activities of Daily Living (ADLs) independently: bathing, dressing, grooming, eating, toileting, mobility/transferring.
2. Decline in ability to accomplish one or more Instrumental Activities of Daily Living (IADLs) independently: shopping, cooking, housekeeping, financial management, transportation, medication management.
3. Confusion or conflict among family, staff, and client about cause for, or amount of decline in, ADLs/IADLs and associated care requirements.
4. Threat to client's safety due to decline in ADLs/IADLs, such as falls, malnutrition, adverse drug reactions, or infections.
5. Conflict between expectations for and actual recovery of function after stroke, hip surgery, or other medical event.
6. Client is unwilling or unable to use adaptive equipment to compensate for decreased function.

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LONG-TERM GOALS

1. Identify cause(s) of decline in ADL/IADL functions and barrier(s) to recovery of function.

2. All involved persons (staff, family, physician, client) reach consensus on cause(s) for disability, prognosis, and a care plan.
3. Increase supervision/assistance to enhance safety.
4. Resolve depression and anxiety that may be interfering with motivation to recover function.
5. Maximize capacity for independent functioning in ADL and IADL spheres.
6. Adapt to current and expected level of function.

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SHORT-TERM OBJECTIVES

1. Consent to participate in evaluation of functional decline if decisionally capable; surrogate consents if the client is not decisionally capable. (1)
2. Client, staff, and family describe decline in function in specific detail. (2, 3)

THERAPEUTIC INTERVENTIONS

1. Obtain consent from the client or surrogate to address the problem of functional decline; include consent to discuss issues with others involved.
2. Explore with the client, staff, and family their perspectives on the decline in the client's function (e.g., sudden versus gradual; precipitated or accompanied by a specific illness, medication, or event; the client's reaction to the decline).
3. Administer a structured instrument, (e.g., Physical Self-Maintenance Scale [PSMS, Lawton and Brody], Rapid Disability Rating Scale [RDRS, Sherwood], the Health Assessment Questionnaire [HAQ, Fries], and the Functional Independence Measure [FIM™, Hamilton] to objectively measure

	the client's or others' reports of functional decline.
3. Cooperate with immediate measures to improve safety. (4, 5)	4. Evaluate the client for the possibility of imminent danger to self, such as infections, malnutrition, falls, and/or adverse drug reactions.
	5. Arrange for the client's immediate protection through installation of safety devices (e.g., grab bars), addition of services (e.g., home health aide), or in severe cases, transfer to a safer environment.
4. Cooperate with a medical evaluation. (6)	6. Refer the client to a physician for evaluation of medical conditions (e.g., Parkinson's disease, stroke, arthritis) and medications (prescribed and OTC) that could be causing his/her decline in function.
5. Cooperate with psychological evaluation. (7)	7. Conduct or refer the client for a psychological evaluation to assess possible contributions of depression and/or anxiety to his/her decline in functional ability.
6. Cooperative with neuropsychological evaluation. (8)	8. Conduct or refer the client for a neuropsychological evaluation to determine if his/her functional decline is associated with cognitive decline.
7. Attend physical therapy evaluation. (9)	9. Refer the client to a physical therapist for an evaluation of his/her mobility-related declines in function, such as balance, gait, endurance, ability to transfer, and range of motion.
8. Participate in occupational therapy assessment. (10)	10. Refer the client to an occupational therapist for an evaluation of his/her ADLs (e.g., bathing, grooming, and hygiene) and IADLs (e.g., driving and cooking).

9. Cooperate with a speech/language evaluation. (11)

10. Accept and participate in a referral to a dietician. (12)

11. Cooperate with recreational therapy assessment. (13)

12. Client, family, and staff verbalize an understanding of cause(s) for decline in function. (14, 15)

13. Client, family, and staff accept prognosis regarding recovery of function. (16, 17, 18)

14. Client, family, and staff agree on care plan to improve function as much as possible. (19, 20, 21, 22)

11. Refer the client to a speech/language therapist for an evaluation of his/her communication skills and swallowing function.

12. Refer the client to a dietician for an evaluation of his/her suspected malnutrition.

13. Refer the client to a recreational therapist for an evaluation of his/her leisure activity function.

14. Discuss and integrate the results of the client's evaluations performed by his/her physician and rehabilitation professionals as appropriate.

15. Meet with the client, family, staff, and other professionals as appropriate to give feedback about the nature, severity, scope, and causes of the functional decline.

16. Explain, or have rehabilitation professionals explain, the client's prognosis for recovery of function.

17. Encourage the client, family, and staff to voice doubts and raise questions about causes/prognosis related to the ADL/IADL decline.

18. Explore with the client and family their emotional reactions to evaluations, including denial, grief, feelings of hope or hopelessness, anger, and related feelings.

19. Introduce the concept of *excess disability* to the client and family, explaining that often negative psychological or environment factors produce disability beyond that which is expected from physical or cognitive causes; by addressing the causes

of excess disability, the client's function can often improve.

20. Establish with the client and family what functions might be improved through addressing psychological or environmental factors.
21. Establish with the client, family, and rehabilitation professionals what functions might be improved through a formal rehabilitation program.
22. Propose and obtain client and family agreement to a care plan for the client that combines all relevant modalities, professionals, and family support.

15. Comply with recommendations to change medications, dosage, or scheduling to improve function. (23)

23. Reinforce the physician's recommendations regarding the client's medications and other treatments that could positively impact his/her ADL/IADL function.

16. Cooperate with treatment for confounding or coexisting depression and anxiety. (24)

24. Address the client's psychological components of excess disability (see the chapters on Depression and Anxiety in this *Planner*).

17. Comply with treatment for rehabilitation of function. (25, 26)

25. Motivate the client to comply with rehabilitation treatment, providing an outlet for ventilation of frustration, but also providing encouragement and reinforcement for completed sessions.
26. Communicate regularly with rehabilitation professionals regarding the client's goals, progress, and psychological status.

18. Use adaptive equipment that can compensate for decreased function. (27)

27. Provide follow-up and encouragement for rehabilitation professional's recommendations

regarding adaptive devices for the client (e.g., walkers or electric carts, communication boards, adaptive utensils, dressing and grooming aids, specialized phones, electronic devices or computers, household safety devices).

19. Comply with rehabilitation recommendations for ongoing changes in lifestyle, and need for increased assistance with ADLS/IADLs. (28)

28. Provide follow-up and monitoring for rehabilitation professional's recommendations regarding the client's lifestyle changes (e.g., patterns of physical exercise, dietary habits, leisure activity schedule).

20. Verbalize an acceptance of increased level of supervision necessary to assure safety or to compensate for decreased independent functioning. (29)

29. Explore the client's feelings about his/her increased dependency and feelings toward those providing assistance.

21. Verbalize and resolve feelings surrounding increased dependency on caregivers. (30, 31)

30. Provide an emotional outlet for the client to discuss ambivalence toward, and conflicts with, caregivers.

31. Help the client resolve conflicts with the caregivers (see the chapter on Interpersonal Conflicts in this *Planner*) and adapt to greater dependency.

22. Identify activities that can be performed as substitutes for those activities that cannot be performed. (32, 33, 34)

32. Have the client, family, and caregivers identify all areas of preserved function.

33. Work with the client, family, and caregivers to identify substitute activities for those that can no longer be performed, such as winding yarn in place of knitting.

34. Assist the client in finding alternative sources of self-esteem; for example, even if arthritic hands can't perform old tasks, they can be beautifully manicured.

23. Reminisce about former accomplishments and relationships that built self-esteem. (35)

35. Use reminiscence to identify and elevate the client's lifelong sources of self-esteem. Teach caregivers to encourage reminiscence through verbal description of events and people, looking at photographs, playing music from earlier eras, and/or handling objects from earlier eras.

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DIAGNOSTIC SUGGESTIONS

ICD-9-CM	*ICD-10-CM*	*DSM-5* Disorder, Condition, or Problem
294.10	F02.80	Probable Major Neurocognitive Disorder Due to Alzheimer's Disease, Without Behavioral Disturbance
294.10	F02.81	Probable Major Neurocognitive Disorder Due to Alzheimer's Disease, With Behavioral Disturbance
290.4	F01.50	Probable Major Vascular Neurocognitive Disorder, Without Behavioral Disturbance
290.4	F01.51	Probable Major Vascular Neurocognitive Disorder, With Behavioral Disturbance
294.9	R41.9	Unspecified Neurocognitive Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
309.9	F43.20	Unspecified Adjustment Disorder
293.84	F06.4	Anxiety Disorder Due to Another Medical Condition
316	F54	Psychological Factors Affecting Other Medical Conditions
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