Section 3

Activities of Daily Living CAP

Problem

The Activities of Daily Living CAP addresses the person's self-sufficiency in performing basic tasks of daily living, including dressing, personal hygiene, walking, transferring, toileting, changing position in bed, and eating.

A decline in a person's ADL self-sufficiency can lead to a wide variety of complications. These complications can include an increase in incontinence, poor communication, cognitive loss, social isolation, depression, falls, and pressure ulcers. For those living in the community, a decline in ADL self-sufficiency is a major precipitator of the person being transferred to a more supervised setting (for example, moving in with others or being transferred to an assisted living or long-term care setting) and can lead to increased use of formal support services.

Many conditions can affect a person's ADL independence. Among the more important include a decline in cognitive performance, the onset or flare-up of a recurrent chronic disease (for example, depression), the emergence of an acute disease (for example, stroke) or health problem (for example, hip fracture), and the inappropriate use of medications.

While new conditions of this type (and especially advancing dementia) can lead to chronic loss of independence in ADLs, following a plan that encourages ADL self-performance often can slow or even reverse functional decline.

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Overall Goals of Care

- Preserve current ADL self-sufficiency levels for as long as possible.
- Monitor a list of specific, potentially troubling acute problems or conditions that can be improved.
- Reverse functional loss resulting from a recent acute event or a condition that can be improved.
- Prevent further functional loss associated with new acute events or a flare-up of chronic conditions that can be improved.
- Improve performance if functioning below capacity.
- Target specific ADL task(s), based on identified inconsistencies between capacity and self-performance, and carry out interventions to improve individualized ADLs.
- Consider referral for physiotherapy (PT) or occupational therapy (OT) services for persons whose ADL function is worse now than 3 months ago or who are performing below capacity.

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Activities of Daily Living CAP Trigger

The goal of this CAP is to improve performance or prevent avoidable functional decline in persons who already have some ADL deficits. The CAP applies to persons

living in independent community housing, persons receiving services from home care programs, persons in assisted living housing, and persons residing in nursing homes (long-stay care residents). The following rules specify the two types of persons triggered for specialized follow-up. A key difference between the two triggered groups is whether the person has a fluctuating functional status or condition at the initial assessment, often indicative of a person who has had a recent acute event.

TRIGGERED TO FACILITATE IMPROVEMENT

Included in this group are persons who have all the following characteristics:

- Receive at least some help in ADLs (but are not totally dependent in all ADLs).
- Have at least some minimal cognitive assets (as indicated by having a Cognitive Performance Scale [CPS] score of less than 6).
- Are not at imminent risk of dying.
- And, have two or more of the following indicators that suggest the person has experienced a recent acute event or has a fluctuating functional status:
  - Experiencing an acute episode or a flare-up of a chronic condition
  - Delirium
  - Changing cognitive status (either improving or worsening)
  - Pneumonia
  - Fall
  - Hip fracture
  - Receiving physical therapy
  - Recent hospitalization
  - Fluctuating ADLs (either improving or deteriorating)
  - Fluctuating care needs (with service supports either increasing or decreasing)

This group includes about 20% of persons in long-term care facilities, 20% of persons receiving home care, and less than 1% of older adults living independently in the community. In a long-term care facility setting, about 33% of the persons triggered into this group will improve over a 90-day period; the rate of improvement in home care is about 21%. At the same time, however, this group is in a precarious position. In long-term care facilities, about 33% will decline over the ensuing 90-day period, while in home care the 90-day decline rate is about 20%.

Principal Approach to Care

Manage the new onset acute problem and work to return the person to his or her pre-acute functional level. Second, watch to ensure the person does not enter a cycle of spiraling ADL decline. About 70% of persons experiencing these types of acute health problems will have either recently declined in ADLs or are at elevated risk of decline over the following 90-day period. For a person who experienced a decline in ADLs at the time of the acute health event, addressing the acute health problem is a key step to the person's return to his or her pre-event functional status. As the acute

problem is relieved, work to make sure the functional loss is reversed to the maximum extent possible.

Also recognize that not all acute-related ADL decline is avoidable. Even with excellent ADL self-maintenance programs, up to 20% of persons with recent onset acute health events will experience a decline in ADL. However, in all cases, reversal of the acute health event and recovery of ADL status is a reasonable goal of care.

TRIGGERED TO PREVENT DECLINE

Included in this group are persons who have all the following characteristics:

- Receive at least some help in ADLs (but are not totally dependent in all ADLs).
- Have at least some minimal level of cognitive assets (as indicated by having a Cognitive Performance Scale score of less than 6).
- Are not at imminent risk of dying.
- And, have **none or only one** of the indicators listed under "Triggered to facilitate improvement." This suggests the person has experienced no more than one recent acute event and does not manifest a fluctuating functional status.

This group includes about 60% of persons in long-term care facilities, 15% of persons receiving home care, and less than 1% of older adults living independently in the community. In a long-term care facility setting, about 33% of the persons triggered into this group will improve over a 90-day period, while 32% will decline. The rate of improvement in home care is about 12%, while the decline rate is about 20%.

Principal Approach to Care

The following two-step strategy is recommended:

- Institute a plan of care to help the person preserve current ADL self-sufficiency levels.
- Watch for the onset of acute health problems or new medications that could drive ADL decline (for example, delirium, change in cognition, pneumonia, new hospitalization) and treat or respond in the earliest phase. The onset of such acute problems will be the principal force that drives functional decline in the months ahead.

NOT TRIGGERED

Included in this group is anyone for whom neither functional recovery nor maintenance to prevent functional decline is the overall goal of care. This group is made up of **three distinct subgroups of persons**:

- The first comprises those persons who independently perform even such early-loss ADLs as dressing and personal hygiene (includes most of the persons receiving home care or living independently in the community who are not triggered).
- The second comprises those who have no residual functional or cognitive assets (CPS score of 6).
- The third comprises those persons who are at imminent risk of dying.

The two latter subgroups make up most of those in long-term care facilities who are not triggered on this CAP.

This group includes about 20% of persons in long-term care facilities, 65% of persons receiving home care, and 99% of older adults living independently in the community. In a long-term care facility setting, about 25% of the persons triggered into this group will decline over a 90-day period, while 12% will improve. The equivalent rate of improvement in home care is about 14%, while the decline rate is about 14%.

- Appropriate ADL monitoring and maintenance care are warranted for those persons with ADL deficits for whom functional recovery or maintenance may not be possible.

Activities of Daily Living CAP Guidelines

Most service programs successfully reach out to some of the persons identified by the ADL CAP triggers, but miss others and provide care to those who would not benefit. Through this ADL review, a greater number of appropriate persons for ADL improvement or maintenance care will be reached and needless functional decline avoided. This approach targets those persons who will benefit most from intensive assessment, monitoring, and intervention. The care can be reasonably performed in any program setting. Care plans and ongoing monitoring will provide extensive interventions to some and less to others.

Approach to improve ADL performance:

- Speak with the person, family, and caregivers to identify new acute episodes. Newly occurring medical, pharmacologic, orthopedic, or vision problems can result in precipitous rates of functional decline. When such conditions occur, note whether ADL functional decline follows. If so, improvement can be expected following the resolution of the acute problem; if ADL issues are not addressed, further decline can be expected. Thus, a referral to a physician is recommended, with information provided on noted clinical changes and consequent functional decline.
- Implement a monitoring program to
  - Inform family and caregivers of the need to watch for the onset of major acute problems that could lead to functional decline (for example, delirium, pneumonia, falls, and hip fractures). When observed, refer the person to a physician.
  - Inform family and caregivers of the need to detect evolving chronic conditions that could lead to functional decline, and especially those that are remediable, such as cataracts or osteoarthritis of the hip or knee.
  - Monitor for inappropriate use of medications leading to functional decline (a newly administered medication, but also a discontinued drug).
  - Check for ADL decline or a drop in activity levels following a recent return from the hospital.

- If symptoms of delirium are present, deliver care in line with the Delirium CAP guidelines. As a part of this effort, review medications to identify drugs that may contribute to delirium and interfere with functioning.
- If dizziness, falls, or recent hip fracture are present, see Falls CAP.
- If the person recently declined or is performing below capacity, refer to or consult with PT or OT, if possible. Persons in this category who receive PT and OT have almost double the rate of improvement over a 90-day period as compared to similar persons who do not receive such care.
- Physicians and other members of the interdisciplinary team need to assess and treat the underlying medical problems.
- If indicators of inadequate nutritional status are present, implement nutritional intervention. [See Undernutrition CAP.]
- If indicators of inadequate pain management are present, review management strategies. [See Pain CAP.]

Review the two interRAI assessment items on the staff's and the person's views of whether further improvements in function are possible. Improvements in performance are more likely and less ADL decline is expected if the person and the staff believe improvement is possible. These items should help guide your view of how to plan and carry out care and services for the person.

Address chronic cognitive loss. Cognitive loss affects a person's potential for ADL improvement and makes it more difficult to lessen functional decline. The cognitive performance items from the interRAI assessment are useful in assessing a person's functional capacity and potential for ADL improvement. Specifically, several of the items in the Cognitive Performance Scale (CPS) can help guide your thinking even when the CPS itself is not calculated. These items include short term memory, decision making, and ability to be understood. [**Note:** See scoring of key interRAI scales for specific guidance on the CPS. The CPS score should be available in your software system.]

- Persons with the greatest deficit in cognition (those with a CPS score of 6) are not triggered on this CAP, as their lack of mental capabilities provide only minimal capacity to improve.
- All other persons are triggered, as ADL performance can often be improved or at least preserved in persons with a CPS score of less than 6.
- Those with no impairment or even persons with moderately impaired cognition (CPS scores of 0, 1, and 2) have the best capacity to improve in ADL.
- Persons with moderately to severely impaired cognition (CPS scores of 3, 4, and 5) need a highly structured ADL plan of care.

Select targeted ADLs for care interventions to prevent further decline and increase independence by comparing self-performance vs. capacity. ADL loss follows a regular, hierarchical pattern. Typically, persons first need help with the so-called "early-loss" ADLs (bathing, dressing, and personal hygiene), followed by the need for help with "middle-loss" ADLs (walking, transfer, toileting), and finally help with "late-loss" ADLs (eating and bed mobility).

- To help preserve — or even improve — ADL self-performance, the person, family, and caregivers can target a specific ADL area for review and potential improvement. For example:
  - For those who are fully independent in walking, focus on an "early-loss" ADL (usually dressing).
  - Focus on "walking" for someone who still has some ability to walk, but is not totally independent.
  - For those who are dependent in walking, focus the care plan on a "late-loss" ADL (usually eating). For example, if the person can still ingest solid foods, provide opportunity and encouragement to self feed. If triggered on the Undernutrition CAP, follow those instructions for such a person.
- Having selected the ADL area around which a program to increase independence will be based, there are many ways to develop a suitable approach to facilitate improvement.
  - At the more formal end of the spectrum of possible approaches, referrals to therapists or an in-house exercise program may be choices often considered. Also consider building a situation-based ADL maintenance and rehabilitation program, focusing on the targeted ADL area. Such an approach is described in the following section.
- At the less formal end of the spectrum of possible approaches, the person and a key family member can be educated on how to facilitate this type of program. Begin by explaining that increased independence is possible. Setting an appropriate expectation is key to change. Then suggest that the person follow a personal version of the formal program described below. The critical elements are as follows: pick an ADL subtask on which to seek greater independence, provide an opportunity for the person to do the subtask, keep track of success and failure, and build upon instances of success.

Example approach to situation-based ADL maintenance and rehabilitation:

- Provide verbal instructions or cueing for each step of a targeted program addressing a specific ADL function.
- Give the person the opportunity to start the activity step, helping as needed.
- Use gestures or verbal cues to which the person responds.
- When a person needs help with a selected task, break the task into segments and set goals for improvement within both tasks and segments.
- Have all care professionals and family members use the same approach every time the ADL activity is performed.
- Continue to use this consistent approach for at least 1 month.
- Document progress in how the person engages in the selected ADL task and each task segment. Note changes in how the person begins the task, if cueing or assistance is needed to start, and if he or she can manage to complete the task once started. It may also be useful in

measuring progress to document the time required to complete each task or subtask.

- Share improvements with caregivers, the person, and family. Sometimes small improvements may not be noticeable to everyone. When well documented, they can be encouraging to everyone involved.

Consequence of functional loss of ADL. Functional loss can also lead to the onset of new problems, including, for example, incontinence, social isolation, depression, falls, accidents, and pressure ulcers. Look for the new onset of such conditions and, as ADLs improve, look for corresponding improvements in these areas.

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