Section 2

Instrumental Activities of Daily Living CAP

Problem

This CAP identifies persons who have the capacity and interest to carry out instrumental activities of daily living (IADLs) more independently. The targeted IADLs include preparing meals, doing ordinary housework (washing dishes, making beds, dusting, tidying up, and so on), shopping, and using public transportation or driving oneself. A loss of full self-sufficiency in IADLs is often the first expression of a later, more widespread general decline in functioning. An estimated 17 to 30% of older adults living in the community have IADL problems, with these numbers rising to about 50% of persons living in elderly housing, and over 95% of persons receiving home care. Of persons who are independent in almost all ADLs but who require assistance in the early-loss ADL of bathing, almost all (about 98%) will also have an IADL problem.

For persons with both interest and capacity to carry out IADLs more independently, there is high potential for useful interventions.

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Overall Goals of Care

- Preserve current IADL self-sufficiency levels for as long as possible and improve performance if functioning is below capacity.
- Monitor for recent acute events, chronic conditions, or symptoms (such as pain) that influence functional status.
- Review and monitor medications.
- Evaluate effect of motivation and mood on functional status.
- Counsel persons on importance of physical activity and exercise, and provide self-management education.
- Depending on level of function, refer persons who are performing below capacity, and especially those who have recently worsened (for example, in the past 3 months), to community programs, exercise counseling, or specialized physical therapy (PT) or occupational therapy (OT) services.
- Discuss preferences for alternate living arrangements for those who have no interest in continuing or assuming responsibility for IADLs

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IADL CAP Trigger

This CAP applies to persons living in home care, assisted living, and independent community housing. Its goal is to identify a subset of persons who are capable of and interested in improving their ability to perform these activities. Four key observations are used to identify persons who will trigger this CAP. First, there must be a belief that the person could improve (including those who have recently declined in functioning). This belief can also be considered a proxy for motivation. Second, the person must have at least some moderate dependency in performing IADLs. Third, the person must not be fully dependent in more basic functioning, as represented by Activities of Daily Living (ADLs) such as dressing. Finally, the person must have at least some cognitive capabilities.

TRIGGERED WITH POTENTIAL TO IMPROVE

This group includes persons who display all four of the following key characteristics:

- **Could improve —** Presence of one or more of the following four items:
  - Person believes she or he could be more independent,
  - Assessor believes person could be more independent,
  - Person judged to have good prospects of recovering from current disease [**Note:** Not an item in interRAI's integrated suite but in version 2.0], and
  - ADL status has become worse.
- **IADL difficulty (capacity)** — A total of 3 or higher (or 7 or higher on interRAI's new suite) on the scale produced by summing the codes for the following difficulty/capacity items: meal preparation, ordinary housework, shopping, and transportation.
- **ADL performance** — A score of 0, 1, 2, or 3 on the ADL Hierarchy Scale, representing levels from "independent" to "receiving extensive assistance with early-loss ADLs."
- **Cognitive performance** — A score of 0, 1, or 2 on the Cognitive Performance Scale (levels from "independent" to "mild impairment").

This triggered group includes 20% of persons receiving home care and 2% of older adults living independently in the community. Over a 90-day period, 15% of this group in a home care program will become more independent in IADL performance. The goal is to increase this percentage.

NOT TRIGGERED

This group includes all other persons. This accounts for about 80% of persons receiving home care and 98% of older adults living independently in the community. For those in this group with IADL deficits, an appropriate response would be limited to providing services that complement the care provided by family and friends.

IADL CAP Guidelines

The following guidelines apply to those persons who trigger the IADL CAP, because they should have the capacity for increased independence in IADLs.

Approach to improve IADL performance:

- Speak with the person and family to identify recent changes. Newly occurring medical issues, pharmacological changes, or recurrence of chronic problems can result in functional decline. Note whether IADL performance is now worse than before the precipitating event. If so, improvement can be expected following resolution of the acute problem, while further decline can be expected if the evolving problem is not addressed.
- Implement monitoring.

Monitor for an acute health problem or the flare-up of a recurrent or chronic problem. Pay particular attention to recent falls, pain, mood, infections, delirium, medications, undernutrition, and vision problems.

- **Falls —** A history of falls usually triggers a program to address issues of balance, postural dizziness, muscle strength, reduced stamina, overly cautious movements, and loss of range of motion (for example, bending, reaching). Thus, if the Falls CAP is triggered, look for the possibility of benefits as the person improves in these areas. [See Falls CAP.]
- **Pain —** One-third to one-half of older adults living independently in the community will experience pain, and the resultant course of care begun when the Pain CAP is triggered will often lead to a decrease of pain levels. Thus, if the Pain CAP is triggered, look for improvement in IADLs as pain is managed. [See Pain CAP.]
- **Mood —** Depression can affect IADL performance because of both withdrawal from activities and the fatigue often associated with this condition. [See Mood CAP.] However, also recognize that the reverse can happen: Decreased IADL capability can result in increased mood problems or decreased feelings of well-being. Thus, improvements in IADLs may have a positive effect on mood state.
- **Infection or other acute events** can affect IADL performance due to secondary effects of inactivity and fatigue.
- **Delirium** can affect IADL performance because of an inability to accomplish usual daily tasks. [See Delirium CAP.]
- **Medications —** Drugs such as anxiolytics, antipsychotics, antidepressants, and hypnotics may induce side effects that result in IADL decline. Consider other drugs that can produce dizziness, hypotension, syncope, balance problems, gait disturbance, and falls. Medication noncompliance or discontinued medication may also contribute to IADL decline. Review the results of the Medications CAP to determine whether medications are contributing to the IADL problem.
- **Monitor nutrition status** if there has been recent weight loss or a low Body Mass Index. [See Undernutrition CAP.]
- **Vision** problems and deteriorating vision can have profound effects on IADL tasks. Rehabilitation strategies and technical aids are available to improve performance in IADLs despite vision loss.

Identify strengths. Persons with good cognition and especially strong motivation will be most able to develop and maintain a program to address IADL loss. Those persons with sufficient financial resources will have greater options to purchase PT and OT services, join an exercise program, or purchase an assistive device. The

availability of supportive family or friends will also help the person through encouragement, co-participation, and assistance.

Address functional problems. About one-half of the observed improvements in IADLs will occur as persons experience improvements in more basic ADL function, cognition, and communication. [See ADL CAP, Cognition Loss CAP, and Communication CAP.] The CAPs in these three areas provide useful information for improving the person's performance. The key from an IADL perspective is to make a conscious link between improvements in these three areas and potential improvements in IADLs. For example, as you note an improvement in ADLs, ask whether this opens opportunities for the person to become more self-sufficient in IADL activities. In fact, assume the answer is "yes." Give the person the opportunity to become more involved in the basic IADLs, for example, helping to assemble the ingredients to cook a meal, mixing the ingredients, or setting the table.

Often, the ADL plan of care will be the primary strategy for introducing a program that will lead to IADL improvements. If the underlying limitation lies in physical performance, review the ADL and Falls CAPs for suggestions to improve balance, strength, and endurance. Depending on the person's level of functioning, exercise programs may be done alone at home, in community centers, or in clubs; alternately, addressing these problems may require a formal specialized program by a physical therapist.

- **Assess the person's detailed performance and opportunities for increased involvement in IADL.** If a person has difficulty with an IADL, break it down into a series of subtasks. For example, meal preparation can be broken down into retrieving food from storage, preparing each item, combining them as needed, cooking them, and serving the meal. Involvement may be encouraged at different steps until the person becomes more confident in performance. Difficulties should be examined to determine whether the underlying problems reflect strength, balance, coordination, or cognitive or organizational problems. From this analysis, seek to identify the specific action or part of an IADL activity for which an assistive device or environmental modification is needed, where skills retraining may be helpful [see ADL CAP], or where the person could be involved if given the opportunity. An occupational therapist may be helpful in both analyzing and making appropriate recommendations.
- **Assess the person's knowledge and skills.** Sometimes, an IADL problem is associated with a lack of skills or knowledge about performance of tasks previously performed by others, such as a spouse. This is relevant to widowed or divorced men when required to do housekeeping, cooking, and shopping —tasks they may have seldom or never before performed. The same may be true for older women with yard work or managing money (paying bills, balancing a checkbook). In these circumstances, the assessment should focus on both the person's willingness and ability to learn new skills to achieve greater IADL independence. Assume the ability is there and schedule practice sessions. For example, take the person on a supermarket outing or sit with the person as he or she writes and posts checks.
- **It is also important to improve knowledge and skills in self-management of chronic conditions.** These are particularly important for conditions that may have flare-ups or reoccur. Check for local availability of self-management programs.

- **Seek opportunities for increased self-performance of IADLs.** Informal caregivers often assume responsibility for IADL activities which, if given sufficient time, the person could either perform or at least assist in performing. It is important that persons be allowed to function within their capacity, and even to expand on their capacity as they display an ability to carry out IADL tasks. Build on a person's strengths.
- **Motivation.** Motivation is a key strength. Persons who are motivated and believe that they have the potential to improve are more likely to demonstrate improvement in performance. Persons with better cognitive function may also be easier to engage in activity programs. Not all persons are motivated to maintain their past level of involvement in IADLs. They may have extended themselves in the past to perform these activities and now, tired, they are seeking help with them. It is important to assess IADL status even for persons known to be receiving help. It is not uncommon for persons to report the need for more help than they are receiving. Some will need training or services, while others may need only counseling and reassurance. Family or friends may assist with IADLs or provide companionship and assurances. However, it is important to avoid premature substitution, that is, the taking over of IADL tasks in which the person was involved previously. "Doing for the person" is often a poor approach to care. Family education on the benefits of active participation is important.

Cognitive training programs. Formal programs that assist with reasoning, decision making, memory, and visual processing have demonstrated effectiveness in reducing functional decline in IADL performance. [See Cognitive Loss CAP.]

Preference alternatives. If a person is no longer interested in assuming responsibility for IADLs or has never been interested, explore alternatives. This situation may arise following the death of a spouse who previously did all the cooking, cleaning, or yard work.

- Begin counseling on the importance of physical activity and exercise, particularly if the person is no longer performing IADLS or has had a decline in activity. [See Physical Activities Promotion CAP.]
- Explore alternate resources for either informal assistance or paid help.
- Initiate discussion on moving to alternate locations such as a continuing care retirement community, a seniors' residence, or an assisted living setting that provides services for meal preparation and housework.
- If considering a move, suggest questions that should be asked of each potential alternative location. For example, check the type and availability of different activities and exercise programs such as strengthening equipment, dance classes, aquatics, and walking groups. Ideally, look for the availability of activities that the person has enjoyed in the past, enjoys now, or is interested in trying.
- Counsel persons to engage in activities that stimulate cognitive function such as bridge, chess, and puzzles. These skills assist in maintenance of IADLs such as finance and medication management.
- Refer persons to self-management programs for their chronic conditions, so that they are better prepared to adjust to fluctuations in status and recover from flare-ups or other acute problems.

Additional Resources

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