Nursing 409 Module 2 Content Part Two

- Atypical Presentation
- Geriatric Syndromes
- Comprehensive Geriatric Assessment
Impact of age and co-morbid conditions

- Multiple and chronic illnesses increase with age
- The likelihood of being disabled by disease doubles every 5 to 7 years

67% of 65yo+ have 2 or more chronic conditions
Average 75yo have 3

- Risk for functional limitation increases
Physiological decline and disease is associated with excess morbidity and resultant disability.

Physical limitation and disability in activities such as stooping, lifting, reaching, grasping and walking.

Community dwelling elders over 40% disabled related to walking alone, increased to over 90% once institutionalized.
Functional Status Impact

- Life expectancy
  - @ 70 without any limitation expectancy is 14+y
  - @ 70 with 1 functional limitation in ADL=11.6 y
  - @ 70 institutionalized even less expectancy
Therefore:

Maintaining function is a vital element in any healthcare decision.
Illness in Older Adults does not fit into current health care practice.

- Current practice outcomes are based on diseases as *single entities*.
- OA’s with co-morbid conditions find themselves on specialized units that are not prepared to address all of their needs.
- They see multiple HCPs who do not communicate effectively
- Many things “fall through the cracks”
Healthcare in relation to the Older Adult needs to develop a new “think”.

Isn’t it about time you started thinking outside the box?
ONE APPROACH TO THE NEW THINK...

CHANGE FOCUS OF TREATMENT

FROM: TREATMENT OF THE SINGLE ENTITY ILLNESS

TO: MANAGEMENT OF MULTIPLE CO-MORBID CONDITIONS
Adults with advanced age and/or complex needs experience a phenomenon no other age group does:

Recently a phrase has been coined…

GERIATRIC SYNDROMES
Geriatric Syndromes

A Geriatric Syndrome primarily refers to:

*One symptom or a complex of symptoms* resulting from:

- *age related changes*,
- *multiple diseases* and
- *risk factors*. 
CURRENT PRACTICE

Traditional Medical Syndrome

Specific morbid process

Multiple phenomenologies

"Moon facies"

"Buffalo Hump"

Truncal obesity

Proximal muscle weakness

Easy bruisability

Skin thinning

Osteoporosis

Cortisol excess

Multiple symptoms resulting from one causative factor
NEW "THINK"
MIRROR IMAGE OF TRADITIONAL SYNDROME

The Geriatric Syndrome

Multiple Morbid Processes

- Dementia
- Dehydration
- Severity of illness
- Sensory impairment
- Medication effects
- Sleep disturbance
- Older age

Delirium syndrome

One symptom or a complex of symptoms resulting from:
age related changes, multiple diseases and risk factors.
GERIATRIC SYNDROME

NOT A DISEASE…
RATHER,
A PHENOMENA
WITH MULTIPLE CAUSATIVE FACTORS
Geriatric Syndrome

“The term “geriatric syndrome” is used to capture those clinical conditions in older persons that do not fit into discrete disease categories”.

Forces health care professionals to treat older adults in light of their symptoms that may not point to causative factors accurately due to atypical presentation.

Geriatric syndromes can stem from

- Multiple diseases
- Adverse drug reactions
- Older age: fragility
- Cognitive impairment
- Baseline functional impairment
- Impaired mobility
Primary Geriatric Syndromes

- Pressure sores
- Pain
- Cognitive impairment: delirium
- Falls
- Urinary incontinence
- Sleep disturbances
- Frailty
- Caregiver stress
ASSESSMENT: PEELING BACK THE LAYERS OF AN ONION
Geriatric Syndromes

- Unique features of common health conditions of older adults
- Highly prevalent
- Multi-factorial
- Associated with substantial morbidity
- Poor outcomes
Other characteristics

Common features:

- Highly prevalent especially in frail older adults
- Affect quality of life and abilities
- Multiple underlying factors involving multiple organ systems
Unresolved and poorly managed Geriatric Syndromes can lead to Cascade Iatrogenesis

- *Cascade iatrogenesis*: spiraling, unintended decline of health from a series of severe effects caused by medical intervention.

- *Iatrogenic complications* are extremely common in hospitalized adults of advanced old age, who have complex illness and long lengths of stay.
Implications for Health Care Providers:

*Early detection & prevention is key*

Risk factors must be **targeted** and **reduced** through early intervention
Implications for Health Care Providers:

- Follow an acceptable standard of practice for a particular clinical entity and

- refrain from unnecessary intervention that may worsen an underlying symptom presenting in a geriatric syndrome
Implications for Health Care Providers:

- Population has a wide range of possible ages (65 years through 100 years and over)

- Plan of care for a 90 year old with chronic illness should differ from that of a 75 year old with the same illness
GERIATRIC SYNDROME: FALLS

Falls among older adults may be isolated occurrences

or

events due to environmental hazards, acute medical illnesses, medications or specific diseases

or

they may be part of the larger geriatric syndrome of functional decline AKA...frailty.
FALLS: PEELING BACK THE LAYERS

Poly Pharmacy
Delirium
Immobility
Vision Impairment
Sleep Deprivation
Infection

8th leading cause of unintentional injury
FUNCTIONAL CONSEQUENCES MODEL
Superimposed on the Geriatric Syndrome: Falls

AGE RELATED FACTORS
- Bone Loss
- Impaired Vision
- Impaired Hearing
- Gait Changes
- Cardiovascular Changes

RISK FACTORS
- Polypharmacy
- Arthritis
- Neuropathies
- Poorly Fitting Shoes
- Side effects of treatment of illnesses
FALLS

Falls among older adults may be isolated occurrences or events due to environmental hazards, acute medical illnesses, medications or specific diseases or they may be part of a larger geriatric syndrome of declining function or frailty.

8th leading cause of unintentional injury
Age related changes in the nervous system affect:

- Gait
- Balance
- Body sway
- Reaction time
Measures for Fall Assessment

- Falls refer to an *event in which the person lands to the lowest level or ground surface*
- Witnessed or un-witnessed
- Often *unreported* especially if the older adult has concurrent CI
- All falls are *important events requiring assessment*, even if their immediate outcome seems trivial, such as no injury or a minor skin scapping
- *Emotional trauma* can occur without physical trauma
Statistics about Falls

- 1 in 5 die within 1 year of a hip fracture
- 1/3 regain their prefracture mobility and independence level
- Number of osteoporotic fractures is 1.3 million/year
- Most are of vertebrae; wrist and hip 1/5 of total
Statistics about Falls

- Cost of falls in 1994 was over 20 billion
- Projected to be over 34 billion in 2020
- Each year 1/3 of people over 65 have a serious fall
- More than 60% who die are over 75 or older
Fall Assessment

- Fall Prevention Programs
  - environmental safety
  - fall risk and post-fall assessment
  - education
  - fall focused plan of care

Case Study

Multi-pronged approach of education, intervention, and exercise reduced falls by 30% and had less injury outcomes
Supporting Evidence to use Falls as a Geriatric Syndrome

- Cognitive decline may occur with treatment interventions
- Risk with cognitive impairment is the **propensity to fall**
- Falls are the **8th leading cause of death** among 65 and over

WHY???

Iatrogenic Cascade

http://www.cdc.gov/HomeandRecreationalSafety/falls/data/cost-estimates.html
Diseases of the Musculoskeletal System Common in Older Adults that Contribute to Falls

- Osteoporosis
- Osteoarthritis
Osteoporosis in Older Adults

Types of Osteoporosis

- Primary Osteoporosis
  - Type I
  - Type II

- Secondary Osteoporosis

http://www.youtube.com/watch?v=rHyeZhcoZcQ&feature=related
Primary Osteoporosis
considered a normal change of aging

- **Type I** – menopausal
  - Rapid loss during first 5-10 years after menopause

- **Type II** – senescent
  - Slower loss that affects both sexes after midlife
  - In women will overlap
Secondary Osteoporosis

- More severe bone loss
- Usually caused by risk factors such as:
  - Ethnicity
  - Family history
  - Non weight-bearing
  - Poor dietary intake of calcium and Vit. D
  - Smoking and alcohol use
  - Medications
  - Illnesses
The ravages of osteoporosis:
Linda, middle-aged, left, and 25 years later, right.
Treatment

- Medications
  - Hormonal therapy: not as recommended
  - Alendronate (Fosamax): treat and prevent
    - 10 mg/day
    - Take with full glass of water
    - Increases BMD } reverses the progression
    - Wait at least 30 minutes before taking other drugs
Prevention Continued

- Promote a diet with adequate calcium and vitamin D
  - 1200-1500 mg./day for calcium with 800-1000 u of D

- Encourage *weight bearing/resistance training* exercises

- Reduce or eliminate smoking

- Reduce or eliminate consumption of beverages with alcohol, caffeine, and phosphorus

- SAFE use of assistive devices
Surgical Treatment

- Vertebroplasty
  
  [Link](http://www.youtube.com/watch?v=T_Ka8uhbL_o&feature=related)

- Balloon Kyphoplasty
  
  [Link](http://www.youtube.com/watch?v=ytSXSDUi_zo&feature=related)
Average Bone Loss
NAME THAT DISEASE

Joints and Connective Tissue

- Diminished viscosity of synovial fluid
- Degeneration of collagen and elastin cells
- Outgrowths of cartilaginous clusters
- Degenerative changes in the arterial cartilage resulting in:
  - Fraying
  - Cracking
  - Shredding
  - Scarring
  - Pitting
  - Thinning
OSTEOARTHRITIS

• http://video.about.com/arthritis/Osteoarthritis.htm
Promoting Musculoskeletal Wellness in Older Adults

Nursing Assessment
- Usual mobility patterns
- Risks for unsafe mobility
- Risks for osteoporosis
- Health behaviors
- Safety of environment

Age-Related Changes
- ↓ muscle mass
- Degenerative changes of joints
- Slower response of central nervous system
- Osteoporosis

Negative Functional Consequences
- ↓ muscle strength and endurance
- ↑ difficulty performing ADL
- ↑ risk for falls and fractures
- Fear of falling

Risk Factors
- ↓ weight-bearing activity
- ↓ calcium and vitamin D
- Tobacco smoking
- Pathologic conditions
- Adverse medication effects
- Environmental factors
- Gait changes
- ↓ sensory function

Nursing Interventions
- Teaching about exercise
- Teaching about prevention of osteoporosis
- Actions to prevent falls and fall-related injuries
- Addressing fear of falling

Wellness Outcomes
- Safer mobility
- ↓ risk for falls
- Prevention of osteoporosis
- ↓ risk for fractures
- Improved quality of life

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Treatment for Osteoporosis and Arthritis

Judicial use of medications such as:
Antinflammatories:
Steroids
NSAIDs

Both have high risks for side effects
Treatment for Osteoporosis and Arthritis

- Exercise participation
  - Adults
    - 15% exercise regularly
    - 25% completely sedentary
    - Sedentary behavior increase with age

30 minutes most if not all days of week needed
Weight Bearing/Resistance Training

- Positively influences
  - Bone density
  - Muscle mass and strength
  - Dynamic balance
  - Functional status
More Good News

- Significant correlation between muscle strength and
  - Independence
  - Ability to perform ADL’s
  - Preferred walking speed
    - Eliminates shuffling
Studies

- Tufts University: Flatarone & Singh
  - Mean age 87
  - Resistance training: 10 weeks 3X per week
  - Results
    - Strength: increased 113%
    - Gait velocity: increased 118%
    - Stair climbing speed: increased 28%
Geriatric Syndrome

- Pressure Sores
AGE RELATED FACTORS

- Thinner dermis
- Flattened dermal-epidermal junction
- Decreased dermal blood supply
- Decreased melanocytes
- Decreased number of sweat and oil glands

GERIATRIC SYNDROME

PRESSURE SORES

RISK FACTORS

- Exposure to ultraviolet rays
- Personal hygiene habits
- Limited activity
- Co-morbidities
- Malnutrition
- Adverse medication effects

AGE RELATED FACTORS

RISK FACTORS
Pressure Ulcers

- Immobility
- Malnutrition
- Declining mental status
- Disuse
- Increase of 63% from 1993-2003
- 72% occur in older adults
- Life Threatening?? YES!!!
Ability to Heal

- Normal aging
  - Delayed immune function
- Chronic disease
  - Protein-energy malnutrition
  - Poor oxygenation
  - Anemia and chronic illness
- Delayed Wound Healing
Nutritional Status As a Risk Factor

- Serum albumin
  - < 3.5 g/dL = low
  - < 2.5 g/dL = serious protein depletion

- Serum transferrin
  - <200 mg/dL = low
  - <100 mg/dL = serious protein depletion

- Lymphocyte
  - <1500 mm³ = energy loss to skin
### BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

<table>
<thead>
<tr>
<th>SENSORY PERCEPTION</th>
<th>Evaluator's Name</th>
<th>Date of Assessment</th>
</tr>
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<tbody>
<tr>
<td>1. Completely Limited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Very Limited</td>
<td></td>
<td></td>
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<tr>
<td>3. Slightly Limited</td>
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<tr>
<td>4. No Impaired</td>
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<tr>
<th>MOISTURE</th>
<th>Evaluator's Name</th>
<th>Date of Assessment</th>
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<tbody>
<tr>
<td>1. Constantly Moist</td>
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<tr>
<td>2. Very Moist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Occasionally Moist</td>
<td></td>
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<tr>
<td>4. Rarely Moist</td>
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<th>ACTIVITY</th>
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<tbody>
<tr>
<td>1. Bedfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Chairfast</td>
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<td></td>
</tr>
<tr>
<td>3. Walks Occasionally</td>
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<tr>
<td>4. Walks Frequently</td>
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<th>MOBILITY</th>
<th>Evaluator's Name</th>
<th>Date of Assessment</th>
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<tbody>
<tr>
<td>1. Completely Immobile</td>
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<td></td>
</tr>
<tr>
<td>2. Very Limited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Slightly Limited</td>
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<td></td>
</tr>
<tr>
<td>4. No Limitation</td>
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<tr>
<th>NUTRITION</th>
<th>Evaluator's Name</th>
<th>Date of Assessment</th>
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<tbody>
<tr>
<td>1. Very Poor</td>
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<tr>
<td>2. Probably Inadequate</td>
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<td></td>
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<tr>
<td>3. Adequate</td>
<td></td>
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<tr>
<td>4. Excellent</td>
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<table>
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<th>FRICITION &amp; SHEAR</th>
<th>Evaluator's Name</th>
<th>Date of Assessment</th>
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<tr>
<td>1. Problem</td>
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<tr>
<td>2. Potential Problem</td>
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<td></td>
</tr>
<tr>
<td>3. No Apparent Problem</td>
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</tbody>
</table>

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**FIGURE 23-3** The Braden Scale is a widely used screening tool to identify people at risk for pressure ulcers. Scores = 15–18, atrisk; 13–14, moderate risk; 10–12, high risk; <9, very high risk. (From Braden B, & Bergstrom, N.,[1988]. Reprinted with permission. Permission to use this tool should be sought at www.bradenscale.com.)
Promoting Skin Wellness in Older Adults

**Nursing Assessment**
- Usual activities that affect skin and risk for skin cancer
- Abnormal skin conditions
- Knowledge about risks and protective behaviors
- Risks for pressure ulcers

**Age-Related Changes**
- ↓ epidermal proliferation
- Thinner dermis, flattened dermal-epidermal junction
- ↓ moisture content
- ↓ sweat and sebaceous glands

**Risk Factors**
- Exposure to ultraviolet light
- Adverse medication effects
- Personal hygiene practices
- Conditions that ↑ risk for pressure ulcers

**Negative Functional Consequences**
- Wrinkles, dry skin
- Slower wound healing
- ↓ sweating, shivering, tactile sensitivity
- ↑ susceptibility to skin cancer
- ↑ susceptibility to burns, bruises, and breakdown

**Nursing Interventions**
- Teaching about self-care for healthy skin
- Teaching about detection and treatment of skin cancer
- Preventing and managing pressure ulcers

**Wellness Outcomes**
- Improved comfort
- Maintenance of intact and healthy skin
- Elimination of risk for skin cancer
- Absence (or quick healing) of pressure ulcers
Other Skin Considerations

- Older adult skin is more prone to injury due to age-related changes
- Normal skin regeneration time doubles from age 30 to age 80
Common types of skin cancer.
(A) Basal cell carcinoma.
(B) Squamous Cell carcinoma.
(C) Melanoma
**Maintaining Healthy Skin**

- Include adequate amounts of fluid in the daily diet.
- Use humidifiers to maintain environmental humidity levels of 40% to 60%.
- Apply emollient lotions twice daily or more often.
- Use emollient lotions immediately after bathing, when the skin is still moist.
- Avoid massaging over bony prominences when applying lotions. Do not use rubbing alcohol.
- Avoid skin care products that contain perfumes or isopropyl alcohol.
- Avoid multiple-ingredient preparations because unnecessary additives may cause allergic responses.
- Inspect skin monthly for suspicious-looking changes.

**Personal Care Practices**

- When bathing or showering, use soap sparingly or use a mild, superfatted, nonperfumed soap (e.g., Castile, Dove, Tone, Basis).
- Maintain water temperatures for bathing at about 90°F to 100°F.
- Make sure skin is well rinsed after soap use. Whirlpool baths stimulate circulation, but moderate temperatures should be maintained.
- Apply emollient products after bathing, rather than using them in the bath water, to minimize the risk for falls on oily surfaces and to maximize the benefits of the emollient.
- Use emollient products containing petrolatum or mineral oil (e.g., Keri, Eucerin, Aquaphor).
- If you use bath oils, take extra safety precautions to prevent slipping.
- If emollient products are applied to the feet, don nonskid slippers or socks before walking.
- Make sure your skin is dried thoroughly, especially between your toes and in other areas where your skin rubs together.
- When drying your skin, use gentle, patting motions rather than harsh, rubbing motions.
- Obtain regular podiatric care.

**Avoiding Sun Damage**

- Wear wide-brimmed hats, sun visors, sunglasses, and long-sleeved garments when exposed to the sun.
- Wear clothing made of cotton, rather than polyester fabrics, because ultraviolet rays can penetrate polyester.
- Apply sunscreen lotions generously and frequently, beginning 1 hour before sun exposure.
- Use sunscreen lotions with an SPF of 15 or higher. Avoid exposure to the sun between 10:00 AM and 3:00 PM.
- Protect yourself from ultraviolet rays even on cloudy days and when you are in the water.
- Artificial tanning booths use ultraviolet type A rays, which are advertised as harmless, but which have been found to cause damage in high doses.

**Preventing Injury From Abrasive Forces**

- Do not use starch, bleach, or strong detergents when laundering clothing or linens.
- Use knit or percale bed linens.
- Use soft terry or cotton washcloths.
- If plastic-lined pads are necessary, make sure that an adequate amount of soft, absorbent material is placed over the plastic.

**Nutritional Considerations**

- Include adequate intake of zinc, magnesium, and vitamins A, B-complex, C, and E.

**Complementary and Alternative Care Practices**

- Herbs for topical use as emollients include aloe vera and calendula.
- Herbs for itching and inflammation include burdock, chickweed, marigold, chamomile, purslane, pineapple, marshmallow, peppermint oil, witch hazel, walnut leaves, and evening primrose oil.
- Bergamot, chamomile, lavender, and geranium can be used for aromatherapy.
COMPREHENSIVE GERIATRIC ASSESSMENT
A multidimensional process designed to assess an elderly person's functional ability, physical health, cognitive and mental health, and socioenvironmental situation.
Why a Specialized Assessment?

Traditional Assessments are focused on determining a "Medical Diagnosis"
Closer to a Functional Assessment

Focused on the measurement of a person’s ability to fulfill responsibilities and perform tasks for self care
Gerontologists Recognized

• The importance of identifying functional impairments as early manifestations of active illness in older people. (Besdine, 1983)

• The importance of assisting the P/F in maintaining the greatest degree of functional independence possible (Williams, 1983)
EVOLUTION OF THE FUNCTIONAL ASSESSMENT USED FOR OLDER ADULTS

1920s  Workers’ compensation developed the concept of functional assessment to measure the loss of function in work activity so that a cash value could be assigned to an impairment.

1940s  Increased numbers of World War II veterans with functional impairments lead to a new emphasis on rehabilitation.

1950s  Gerontologists developed point system scales to measure basic and more complex activities of daily living.

1960s  Functional assessment scales were broadened to assess the influence of the environment on the person’s level of function.

1970s  Researchers and planners began using functional assessment measures.

1980s  Gerontological practitioners recognized the clinical value of functional assessment tools and began using them in health care settings.

1990s  Functional assessment scales were developed to address the interplay between cognition and functioning in daily activities for people with dementia.

1987...Development of the Minimum Data Set (MDS) & the Resident Assessment Instrument (RSI) and Federally mandated to be used by all Medicare/Medicaid Facilities.
Expanded to Include:

- Everyday competence which evaluates a person’s ability to:
  - Perform tasks in addition to daily behaviors such as managing finances
  - Coordinate physical, cognitive, emotional and social functioning

Strong emphasis on sensitivity to cultural and contextual factors that affect behavior
Tools Developed Include the: Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Available in the Try This series from the Hartford... see next 2 slides
### Katz Index of Independence in Activities of Daily Living

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>INDEPENDENCE: (1 POINT) NO supervision, direction or personal assistance</th>
<th>DEPENDENCE: (0 POINTS) WITH supervision, direction, personal assistance or total care</th>
</tr>
</thead>
<tbody>
<tr>
<td>BATHING</td>
<td>(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.</td>
<td>(0 POINTS) Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.</td>
</tr>
<tr>
<td>POINTS:________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRESSING</td>
<td>(1 POINT) Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.</td>
<td>(0 POINTS) Needs help with dressing self or needs to be completely dressed.</td>
</tr>
<tr>
<td>POINTS:________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOILETING</td>
<td>(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.</td>
<td>(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.</td>
</tr>
<tr>
<td>POINTS:________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRANSFERRING</td>
<td>(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.</td>
<td>(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.</td>
</tr>
<tr>
<td>POINTS:________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONTINENCE</td>
<td>(1 POINT) Exercises complete self control over urination and defecation.</td>
<td>(0 POINTS) Is partially or totally incontinent of bowel or bladder.</td>
</tr>
<tr>
<td>POINTS:________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FEEDING</td>
<td>(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.</td>
<td>(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.</td>
</tr>
<tr>
<td>POINTS:________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL POINTS = _______**

6 = High (patient independent) 0 = Low (patient very dependent)

THE LAWTON INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE

Ability to Use Telephone
1. Operates telephone on own initiative; looks up and dials numbers ........................................ 1
2. Dials a few well-known numbers ......................... 1
3. Answers telephone, but does not dial ................... 1
4. Does not use telephone at all ................................ 0

Shopping
1. Takes care of all shopping needs independently ....... 1
2. Shops independently for small purchases .............. 0
3. Needs to be accompanied on any shopping trip ...... 0
4. Completely unable to shop ................................ 0

Food Preparation
1. Plans, prepares, and serves adequate meals
   independently ............................................. 1
2. Prepares adequate meals if supplied with ingredients 0
3. Heats and serves prepared meals or prepares meals
   but does not maintain adequate diet .................. 0
4. Needs to have meals prepared and served ............. 0

Housekeeping
1. Maintains house alone with occasion assistance
   (heavy work) .............................................. 1
2. Performs light daily tasks such as dishwashing, bed
   making ..................................................... 1
3. Performs light daily tasks, but cannot maintain
   acceptable level of cleanliness ....................... 1
4. Needs help with all home maintenance tasks ........ 1
5. Does not participate in any housekeeping tasks ...... 0

Laundry
1. Does personal laundry completely ....................... 1
2. Launders small items, rinses socks, stockings, etc. ... 1
3. All laundry must be done by others ..................... 0

Mode of Transportation
1. Travels independently on public transportation or
   drives own car ............................................ 1
2. Arranges own travel via taxi, but does not otherwise
   use public transportation ........................... 1
3. Travels on public transportation when assisted or
   accompanied by another ............................. 1
4. Travel limited to taxi or automobile with assistance
   of another ............................................... 0
5. Does not travel at all ................................... 0

Responsibility for Own Medications
1. Is responsible for taking medication in correct
   dosages at correct time .............................. 1
2. Takes responsibility if medication is prepared in
   advance in separate dosages ....................... 0
3. Is not capable of dispensing own medication .......... 0

Ability to Handle Finances
1. Manages financial matters independently (budgets, writes
   checks, pays rent and bills, goes to bank; collects and
   keeps track of income) ............................. 1
2. Manages day-to-day purchases, but needs help with
   banking, major purchases, etc ..................... 1
3. Incapable of handling money .......................... 0

Scoring: For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1).

A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women, and 0 through 5 for men.


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SCORE
See next two slides for the part of a Tool that focuses on function:

Miller pps. 94-111

Note: Additional columns added for ongoing assessment.

The Comprehensive Assessment builds on itself overtime and forms a portrait of the client as he/she ages.
## Functional Assessment of Older Adults

This form allows for recording changes over time. The three time designations indicated on the form signify the period prior to admission (PTA), the time of admission (ADM), and the day of discharge (DISCH). The unmarked columns may be used at any time after discharge, or upon readmission. (Used with permission from Fairview General Hospital, Cleveland, OH.)

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FIGURE 7-2 (continued)
ASSESSING FUNCTION IN THE COGNITIVELY IMPAIRED OLDER ADULT

THE CLEVELAND SCALE FOR ACTIVITIES OF DAILY LIVING

This scale is sensitive enough to measure changes in those with dementia.

SEE MILLER PAGES 102 TO 105