

GUIDE

NATIONAL
INSTITUTE
for
MEDICAL
RESPITE
CARE

Clinical Guidelines for Medical Respite/ Recuperative Care

Activities of Daily Living

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Introduction

Activities of daily living (ADL) are an essential part of caring for oneself. People experiencing homelessness face significant barriers to engaging in ADL regularly including unavailable or inaccessible environments, unpredictable or unstructured routines, and co-occurring disability (e.g., physical, mental, cognitive) (1,2). Additionally, this population experiences disproportionate levels of chronic illnesses and traumatic brain injury (TBI) that increase the risk for functional impairment and experience these conditions at an earlier age than the general population (3, 4, 5). Individuals referred to medical respite/recuperative care* programs have likely experienced at least one chronic illness and may be facing new functional limitations as a result of a recent or acute medical condition, prompting their need for care. It is not recommended for programs to provide the same level of care for ADL as is provided in skilled nursing (SNF), inpatient rehabilitation (IRF), or long-term care (LTC) facilities. However, some ADL limitations can effectively be addressed or accommodated within medical respite/recuperative care programs, which could improve outcomes for patients with previously unidentified ADL limitations and enhance access to beneficial respite services for those who may be otherwise considered ineligible. Programs should utilize this guideline to consider modifications to their programs and admission criteria while maintaining safety, an appropriate scope of practice, and conscientious utilization of available respite beds and services. This document provides guidance to understanding ADL, levels of assistance, and potential interventions that may be implemented within the medical respite setting.

KEY TERMS & DEFINITIONS

Activities of Daily Living (ADL) are activities oriented toward taking care of one's own body and completed on a routine basis. ADL include: bathing & showering, toileting & toilet hygiene, dressing, feeding, eating & swallowing, functional mobility, personal hygiene & grooming, and sexual activity (6).

Levels of Assistance describe the amount of support a person needs to complete an activity, such as an ADL (7). The levels of assistance are as follows:

Independent	Person completes the activity by themselves with no assistance from a helper (with or without adaptive equipment).
Set-up or cleanup assistance	Helper sets up or cleans up; person completes activity. Person assists only prior to or following the activity (the helper can walk away and leave the person to complete the tasks).
Supervision or Touching Assistance	Helper provides verbal cues or touching/steadying and/or contact guard assistance as person completes activity. Assistance may be provided through the activity or intermittently.
Partial/ Moderate Assistance	Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs but provides less than half the effort.
Substantial/ Maximal Assistance	Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
Total Assistance	Helper does all of the effort. Person does none of the effort to complete the activity, Or, the assistance of 2 or more helpers is required for the person to complete the activity.

Clinical Considerations

FACTORS IMPACTING ADL

Limitations in ADL may be caused by:

- Physical health, such as decreased balance, endurance, cardiorespiratory function, vision, or strength.
- Mental health, such as decreased motivation or organization, anxiety, or symptoms related to drug use and withdrawal.
- Cognitive health, such as decreased executive functioning or awareness.
- Sensory function, such as pain, impaired body awareness or presence of neuropathy in hands or feet.
- Fear of falling may also result and impede participation in ADL.
- Restrictive and inaccessible environments, requiring adaptation and limiting participation in ADL.

Changes in function may be caused by:

- A medical diagnosis or event (e.g., a stroke resulting in unilateral weakness),
- Exacerbation of symptoms (e.g., worsening depression), or
- Medication changes (e.g., foggiess, dizziness, mood changes).
- Changes and limitations in ADL performance may be temporary or long-term, depending on the cause and progression of illness. Those with both temporary and long-term limitations will benefit from an opportunity to rehabilitate or develop adaptive and compensatory strategies, increasing independence and safety. Need for long-term support is a critical consideration for discharge planning.

ASSESSMENT

In all assessment processes, it is important to implement a trauma-informed approach.

Motivational Interviewing can be used to assess the person's priorities and concerns regarding ADL performance and collaboratively identify and explore current barriers or supports needed.

History and Physical to identify underlying or co-occurring health issues impacting functional and ADL performance.

Environmental Assessment can determine the accessibility of ADL and personal care spaces, privacy and safety concerns, and potential adaptations to the physical space.

Occupational Therapy (OT) evaluation to identify underlying factors and impact of health conditions and environmental barriers on ADL performance.

Physical Therapy (PT) evaluation to identify underlying physiological factors and impact of health conditions and mobility on ADL performance.

Recommended Strategies

Strategies implemented should be person-centered, collaborative, and based on barriers identified during the assessment process. The person should be involved in identifying and planning how strategies will be used. Programs also need to evaluate their staff roles and capacity to provide different types of assistance, and determine who is most appropriate to provide identified assistance or supports.

PERSON-SPECIFIC STRATEGIES

- Identify an action plan to integrate strategies and supports.
- Assist in accessing or provide needed ADL supplies.
- Establish personal routines and schedules.
- Assist in set-up of ADL tasks.
- Provide verbal cuing or prompting to begin task or use identified strategies.
- Establish methods for organization of personal belongings.
- Identify and support alternative methods to complete ADL.
- Assist in accessing or provide needed adaptive equipment and accessible clothing.
- Address concerns or emotional adjustment to new limitations or diagnoses.

ENVIRONMENTAL STRATEGIES

- Increase accessibility of bathrooms, such as installing grab bars at ADA -recommended heights or shower chairs.
- Increase accessibility of sink and hygiene spaces, including roll-under spaces for wheelchair access and/or turning radius space for walker and wheelchair entry.
- Assist the person in setting up the space prior to beginning ADL activity
- Increase lighting in rooms and hallways.
- Minimize clutter and ensure clear pathways.
- Use a variety of furniture and seating options.
- Have an ADA consultant, OT, or PT complete an environmental assessment with recommendations.

REFERRALS

The following referrals may be beneficial to address ADL needs:

- Occupational Therapy
- Physical Therapy
- Behavioral health to address symptoms or adjustment to new limitations
- Specialists for underlying conditions such as neurology, urology, rehabilitation medicine, and psychiatry

DISCHARGE PLANNING

Discharge planning for someone with ADL limitations can be difficult due to the lack of accessibility in many communities and shelter environments. Although housing is the ideal discharge setting for those with a sufficient degree of functional independence, even available housing may lack accessibility features. Considerations for preparing for discharge include:

- What is the accessibility of potential discharge placement options?
- What equipment does the person need, will they have access to it and will they be able to use it?
- Is the person eligible for ongoing services from Personal Care Assistants (PCA)?
- What are the person's preferences at discharge for ADL needs and support?
- Will some functional impairments persist and warrant continued support or higher levels of care?

For those with long-term needs, decompensation in condition or skills, or who present with a safety risk, alternative discharge options should be pursued. Questions to consider include:

- Is the person willing to transition to a higher level of care?
- What does the person qualify for (e.g., SNF, LTC, home and community-based services)?
- What documentation is needed to support this transition?
- What is the time frame for transition, and can the person stay within the respite program until that happens?
- What outside services are available to support the person and work towards transition if the medical respite program cannot accommodate an extended stay?
- How does the program maintain safety until the person is transitioned?

Advanced Training & Advocacy

Additional resources and training to address ADL include:

- Safe patient handling and transfer training.

Advocacy efforts to improve performance and quality of life for individuals with ADL needs include:

- Access to disability services and resources (including knowledge of rights [e.g., ADA, Rehabilitation Act, Fair Housing Act], connections to and collaborations with Centers for Independent Living, etc.)
- Increasing accessibility of shelters, supportive housing, and subsidized housing.
- Increasing access to SNF, IRF, and (community-integrated) LTC services for those with Medicaid or who are uninsured.
- Integrating principles of harm reduction and trauma-informed care in traditional rehabilitation and long-term care settings.

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Case Examples

CASE EXAMPLE 1

Background: Barbara is a 54-year-old who identifies as female. She was referred to the medical respite program following hospitalization due to a fall while at a family member's house. Barbara also has left-sided weakness following a stroke and a right leg above-knee amputation due to complications from diabetes. After losing her housing during the hospitalization for the stroke, Barbara has been staying intermittently with various family members. Due to lack of mobility and support resources, she has been unable to attend PT appointments to fit and use a prosthetic leg.

After admission to the medical respite program, Barbara sustained a fall while transferring into the shower, but did not sustain any injuries. She also fluctuated in reporting her independence in tasks, but also frequently requested assistance from staff for showering and dressing.

Assessment: With support of the RN and community health worker, Barbara discussed her mobility needs with the physical therapist who completed an evaluation in addition to addressing the prosthetic fit process. An assessment with behavioral health identified Barbara experienced increased anxiety due to mobility limitations, resulting in low tolerance for more difficult and time-consuming ADL tasks. Occupational therapy evaluation identified barriers to ADL, including mild-moderate cognitive impairment and accessibility needs in the environment. The RN was able to modify health and medication education in response to the identified cognitive impairment.

Intervention: With care coordination support, Barbara continued participation in outpatient PT and home health OT services to increase safety in mobility and implement adaptive strategies for ADL that addressed both physical and cognitive needs. Strategies implemented onsite included encouraging Barbara to shower at times when she had more time and did not feel the need to rush, providing adaptive equipment for bathing and dressing tasks, and assisting Barbara in organizing her space and belongings to prevent falls and more effectively plan ahead for her ADL. She also continued with behavioral health care to address her mental health changes as a result of health and housing loss.

Outcomes: Barbara was able to complete her PT successfully to use both a prosthetic and wheelchair for mobility. She expressed the benefit of learning new strategies for ADL in a supportive environment and felt more confident in addressing her health needs.

CASE EXAMPLE 2

Background: Jordan is a 46-year-old who identifies as male. He was referred to the medical respite program following an emergency room visit for significant bilateral leg wounds. Jordan's co-occurring diagnoses include congestive heart failure and schizophrenia. Prior to his ER visit, Jordan was primarily sleeping in a park that was close to various resources, including a daily meal program. The goal for Jordan's admission was resolution and healing of his wounds.

After a week at the medical respite program, staff noticed that Jordan did not appear to be engaging in the ADL of showering or completing dressing changes as indicated by his ER discharge paperwork. Jordan was also observed to ambulate slowly and have difficulty lifting his legs into bed and a tub.

Assessment: The staff engaged with Jordan to identify potential barriers to showering to support his recovery and wound care. The behavioral health therapist used motivational interviewing to identify that Jordan was experiencing paranoia and did not want to shower for long periods of time without his bag of belongings. Jordan's nurse identified that he was unsure of how to implement the guidelines given to him in the ER to change and clean his wounds, and he had also avoided showering due to this uncertainty. An occupational therapy evaluation revealed that Jordan was unable to carry his bag of belongings and ADL supplies at the same time into the shower due to decreased mobility and increased fatigue, and also did not know how to use the available adaptive equipment. He additionally demonstrated signs of fear of falling. It was also determined by the team that he likely had decreased initiation and problem-solving skills as a result of his mental health symptoms.

Intervention: Several strategies were implemented to support Jordan while at the respite program. Jordan received training and practice to learn to use adaptive equipment and set-up his space to safely shower. Jordan agreed to shower on days he needed to change his wound dressings, and benefited from staff verbal reminders of the schedule. He initially received intensive nurse education and support for dressing changes. Jordan required assistance to carry supplies and his belongings into the shower space, but this decreased as his wounds healed and ambulation improved.

Outcome: Eventually, Jordan's recovery allowed him to complete all steps independently to shower and needing only occasional reminders. He transitioned to completing dressing changes with supervision until his wounds were healed. Jordan declined a psychiatry referral but did agree to completing an application for a permanent supportive housing program.