

Patient Name: _____

Date: _____

Patient ID # _____

Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	Independence (1 Point)	Dependence (0 Points)
	NO supervision, direction or personal assistance.	WITH supervision, direction, personal assistance or total care.
BATHING Points: _____	(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.	(0 POINTS) Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: _____	(1 POINT) Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	(1 POINT) Exercises complete self control over urination and defecation.	(0 POINTS) Is partially or totally incontinent of bowel or bladder
FEEDING Points: _____	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.
TOTAL POINTS: _____	SCORING: 6 = High (<i>patient independent</i>) 0 = Low (<i>patient very dependent</i>)	

Source:

try this: Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.

Patient Name: _____

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**LAWTON - BRODY
INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (I.A.D.L.)**

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

A. Ability to Use Telephone		E. Laundry	
1. Operates telephone on own initiative-looks up and dials numbers, etc.	1	1. Does personal laundry completely	1
2. Dials a few well-known numbers	1	2. Launders small items-rinses stockings, etc.	1
3. Answers telephone but does not dial	1	3. All laundry must be done by others	0
4. Does not use telephone at all	0		
B. Shopping		F. Mode of Transportation	
1. Takes care of all shopping needs independently	1	1. Travels independently on public transportation or drives own car	1
2. Shops independently for small purchases	0	2. Arranges own travel via taxi, but does not otherwise use public transportation	1
3. Needs to be accompanied on any shopping trip	0	3. Travels on public transportation when accompanied by another	1
4. Completely unable to shop	0	4. Travel limited to taxi or automobile with assistance of another	0
		5. Does not travel at all	0
C. Food Preparation		G. Responsibility for Own Medications	
1. Plans, prepares and serves adequate meals independently	1	1. Is responsible for taking medication in correct dosages at correct time	1
2. Prepares adequate meals if supplied with ingredients	0	2. Takes responsibility if medication is prepared in advance in separate dosage	0
3. Heats, serves and prepares meals, or prepares meals, or prepares meals but does not maintain adequate diet	0	3. Is not capable of dispensing own medication	0
4. Needs to have meals prepared and served	0		
D. Housekeeping		H. Ability to Handle Finances	
1. Maintains house alone or with occasional assistance (e.g. "heavy work domestic help")	1	1. Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank), collects and keeps track of income	1
2. Performs light daily tasks such as dish washing, bed making	1	2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.	1
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness	1	3. Incapable of handling money	0
4. Needs help with all home maintenance tasks	1		
5. Does not participate in any housekeeping tasks	0		
Score		Score	

Total score _____

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

Issue Number 2, Revised 2007

Series Editor: Marie Boltz, PhD, GNP-BC

Series Co-Editor: Sherry A. Greenberg, MSN, GNP-BC
New York University College of Nursing

Katz Index of Independence in Activities of Daily Living (ADL)

By: Meredith Wallace, PhD, APRN, BC, Fairfield University School of Nursing, and Mary Shelkey, PhD, ARNP, Virginia Mason Medical Center

WHY: Normal aging changes and health problems frequently show themselves as declines in the functional status of older adults. Decline may place the older adult on a spiral of iatrogenesis leading to further health problems. One of the best ways to evaluate the health status of older adults is through functional assessment which provides objective data that may indicate future decline or improvement in health status, allowing the nurse to intervene appropriately.

BEST TOOL: The Katz Index of Independence in Activities of Daily Living, commonly referred to as the Katz ADL, is the most appropriate instrument to assess functional status as a measurement of the client's ability to perform activities of daily living independently. Clinicians typically use the tool to detect problems in performing activities of daily living and to plan care accordingly. The Index ranks adequacy of performance in the six functions of *bathing, dressing, toileting, transferring, continence, and feeding*. Clients are scored yes/no for independence in each of the six functions. A score of 6 indicates full function, 4 indicates moderate impairment, and 2 or less indicates severe functional impairment.

TARGET POPULATION: The instrument is most effectively used among older adults in a variety of care settings, when baseline measurements, taken when the client is well, are compared to periodic or subsequent measures.

VALIDITY AND RELIABILITY: In the thirty-five years since the instrument has been developed, it has been modified and simplified and different approaches to scoring have been used. However, it has consistently demonstrated its utility in evaluating functional status in the elderly population. Although no formal reliability and validity reports could be found in the literature, the tool is used extensively as a flag signaling functional capabilities of older adults in clinical and home environments.

STRENGTHS AND LIMITATIONS: The Katz ADL Index assesses basic activities of daily living. It does not assess more advanced activities of daily living. Katz developed another scale for instrumental activities of daily living such as heavy housework, shopping, managing finances and telephoning. Although the Katz ADL Index is sensitive to changes in declining health status, it is limited in its ability to measure small increments of change seen in the rehabilitation of older adults. A full comprehensive geriatric assessment should follow when appropriate. The Katz ADL Index is very useful in creating a common language about patient function for all practitioners involved in overall care planning and discharge planning.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGeriRN.org.

Graf, C. (2006). Functional decline in hospitalized older adults. *AJN*, 106(1), 58-67.

Katz, S., Down, T.D., Cash, H.R., & Grotz, R.C. (1970) Progress in the development of the index of ADL. *The Gerontologist*, 10(1), 20-30.

Katz, S. (1983). Assessing self-maintenance: Activities of daily living, mobility and instrumental activities of daily living. *JAGS*, 31(12), 721-726.

Kreševic, D.M., & Mezey, M. (2003). Assessment of function. In M. Mezey, T. Fulmer, I. Abraham (Eds.), D. Zwicker (Managing Ed.), *Geriatric nursing protocols for best practice* (2nd ed., pp 31-46). NY: Springer Publishing Co., Inc.

Mick, D.J., & Ackerman, M.H. (2004, Sept). Critical care nursing for older adults: Pathophysiological and functional considerations. *Nursing Clinics of North America*, 39(3), 473-93.



try this: **Best Practices in Nursing Care to Older Adults**

from **The Hartford Institute for Geriatric Nursing**
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Managing Editor: Sherry A. Greenberg, MSN, APRN, BC, GNP
New York University College of Nursing

The Lawton Instrumental Activities of Daily Living (IADL) Scale

By: Carla Graf, MS, APRN, BC, University of California, San Francisco

WHY: The assessment of functional status is critical when caring for older adults. Normal aging changes, acute illness, worsening chronic illness, and hospitalization can contribute to a decline in the ability to perform tasks necessary to live independently in the community. The information from a functional assessment can provide objective data to assist with targeting individualized rehabilitation needs or to plan for specific in-home services such as meal preparation, nursing care, home-maker services, personal care, or continuous supervision. A functional assessment can also assist the clinician to focus on the person's baseline capabilities, facilitating early recognition of changes that may signify a need either for additional resources or for a medical work-up (Gallo, 2006).

BEST TOOL: The Lawton Instrumental Activities of Daily Living Scale (IADL) is an appropriate instrument to assess independent living skills (Lawton & Brody, 1969). These skills are considered more complex than the basic activities of daily living as measured by the Katz Index of ADLs (See *Try this:* Katz Index of ADLs). The instrument is most useful for identifying how a person is functioning at the present time, and to identify improvement or deterioration over time. There are eight domains of function measured with the Lawton IADL scale. Women are scored on all 8 areas of function; historically, for men, the areas of food preparation, housekeeping, laundering are excluded. Clients are scored according to their highest level of functioning in that category. A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women, and 0 through 5 for men.

TARGET POPULATION: This instrument is intended to be used among older adults, and can be used in community or hospital settings. The instrument is not useful for institutionalized older adults. It can be used as a baseline assessment tool and to compare baseline function to periodic assessments.

VALIDITY AND RELIABILITY: Few studies have been performed to test the Lawton IADL scale psychometric properties. The Lawton IADL Scale was originally tested concurrently with the Physical Self-Maintenance Scale (PSMS). Reliability was established with twelve subjects interviewed by one interviewer with the second rater present but not participating in the interview process. Inter-rater reliability was established at .85. The validity of the Lawton IADL was tested by determining the correlation of the Lawton IADL with four scales that measured domains of functional status, the Physical Classification (6-point rating of physical health), Mental Status Questionnaire (10-point test of orientation and memory), Behavior and Adjustment rating scales (4-6-point measure of intellectual, person, behavioral and social adjustment), and the PSMS (6-item ADLs). A total of 180 research subjects participated in the study, however, few received all five evaluations. All correlations were significant at the .01 or .05 level. To avoid potential gender bias at the time the instrument was developed, specific items were omitted for men. This assessment instrument is widely used both in research and in clinical practice.

STRENGTHS AND LIMITATIONS: The Lawton IADL is an easy to administer assessment instrument that provides self-reported information about functional skills necessary to live in the community. Administration time is 10-15 minutes. Specific deficits identified can assist nurses and other disciplines in planning for safe discharge. Limitations of the instrument can include the self-report or surrogate report method of administration rather than a demonstration of the functional task. This may lead either to over-estimation or under-estimation of ability. In addition, the instrument may not be sensitive to small, incremental changes in function.

FOLLOW-UP: The identification of new disabilities in these functional domains warrants intervention and further assessment to prevent ongoing decline and to promote safe living conditions for older adults. If using the Lawton IADL tool with an acute hospitalization, nurses should communicate any deficits to the physicians and social workers/case managers for appropriate discharge planning.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGerIRN.org.

Gallo, J.J., & Paveza, G.J. (2006). Activities of daily living and instrumental activities of daily living assessment. In J.J. Gallo, H.R. Bogner, T. Fulmer, & G.J. Paveza (Eds.), *Handbook of Geriatric Assessment* (4th ed., pp. 193-240). MA: Jones and Bartlett Publishers.

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Pearson, V. (2000). Assessment of function. In R. Kane, & R. Kane (Eds.), *Assessing Older Persons. Measures, Meaning and Practical Applications* (pp. 17-48). New York: Oxford University Press.

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