Assessment and Prevention of Geriatric Functional Decline

Jessica Tully MSN, RN-BC, CMSRN, CNML

Purpose

Identify hospitalized geriatric patients at risk for functional decline & reduce the incidence of further decline

Background & Organizational Info

- ◆ Patients experience additional functional decline while hospitalized
- ◆ There is a deficiency in methods to identify patients at risk for functional decline

Significance & Evidence

- ◆ Increased geriatric population
- ◆ 30-60% of older patients experience functional decline at and following hospitalization
- ◆ Katz Independence of Daily Living has an established reliability of 0.94-0.97

Implementation

- ◆ Creation and implementation of a Katz form with interventions for patients in the Acute Care for Elders (ACE) Unit
- ◆ Education for nurses to complete assessment for:
  - ➢ 3 months before admission
  - ➢ On admission
  - ➢ At discharge

Assessment for: ____Past 3 Months before admission ____Initial Admit to ACE Unit ____Discharge

Katz Index of Independence in Activities of Daily Living

Activity	Independence = 1 Point (No supervision, direction, or assistance needed to complete task)	Dependence = 0 Points (Requires supervision, direction, assistance, or total care)
Bathing Points: 0 1	Bathes self completely or needs assistance with single part of body (ex. back, genital area, etc.).	Needs assistance with more than one part of the body, getting into or out of the shower, or total assistance.
Dressing Points: 0 1	Gets clothes and puts them on (including buttoning etc.) without assistance. May have assistance tying shoes.	Needs assistance with dressing or needs to be completely dressed.
Toileting Points: 0 1	Goes to the toilet, gets on and off, cleans genital area, and arranges clothes without assistance.	Needs help transferring to toilet/commode, cleaning self, or uses bedpan.
Transferring Points: 0 1	Moves in and out of bed or chair without assistance. Use of walker or cane etc. is acceptable.	Needs assistance in moving from bed to chair or requires a complete transfer.
Continence Points: 0 1	Complete self control for urination and defecation.	Partial or totally incontinent for urination or defecation.
Feeding Points: 0 1	Feeds self without help. May have assistance with preparing the food to eat.	Needs partial or total assistance with feeding or on parenteral feeding.
Total Score = ________	6 = Full function	4 = Moderate Impairment 2 or Less = Severe Impairment

Healthcare Provider Interventions

(if not contraindicated by licensed care provider orders)

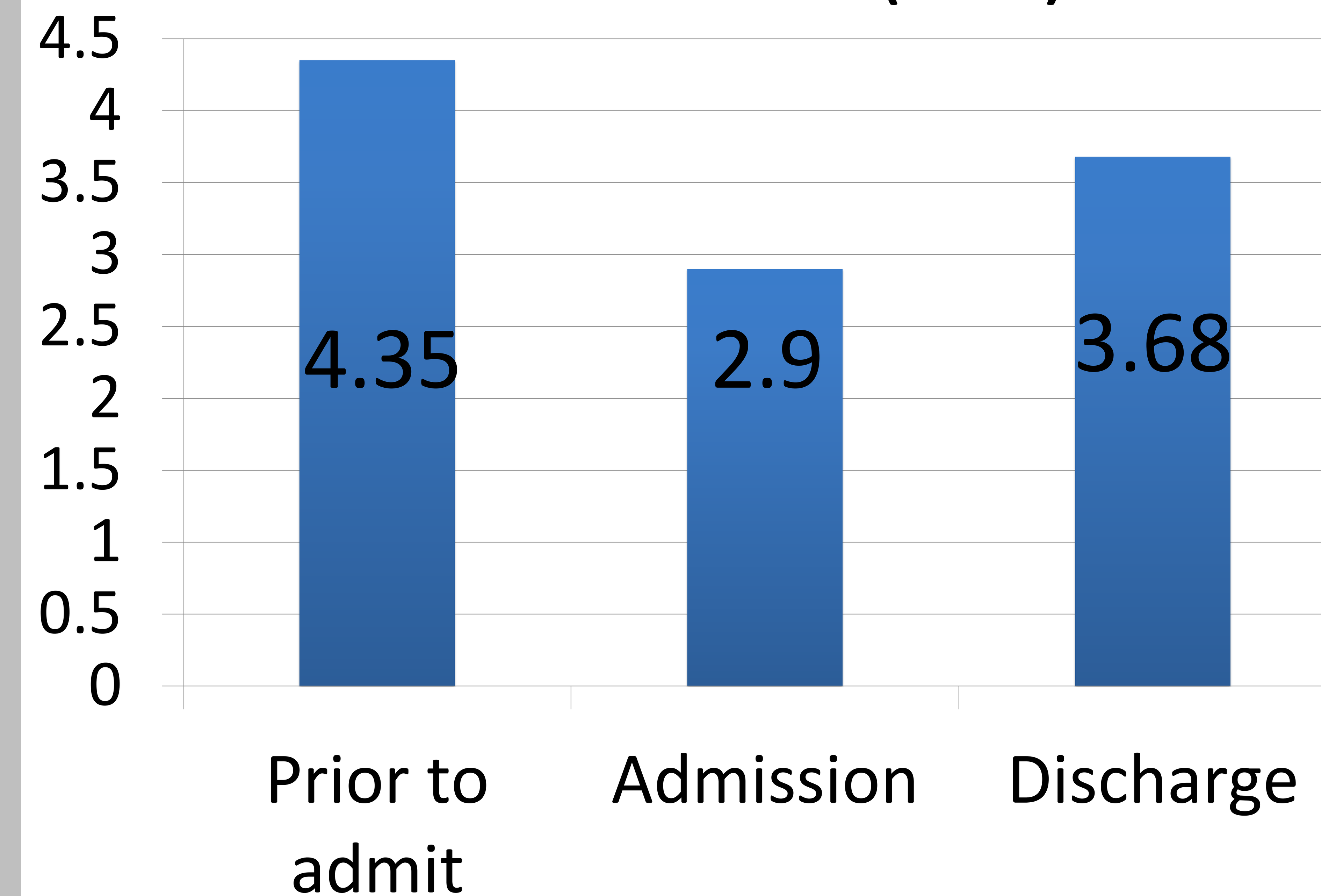
Score of 6-5

- Ensure patient ambulates at least twice daily.
- Ensure patient is up to chair for meals.

Score of 4 or less

- Ensure patient is up to chair for meals.
- Assist with ambulation in hallway if patient is capable.
- Ensure physical therapy screen is ordered and communicate with licensed care provider if patient will benefit from a physical therapy consult.

Outcomes



Patients:

- ➢ Had a significant decrease in function on admission when compared to prior to admission levels
- ➢ Had a significant increase in function on discharge
- ➢ Did not achieve their previous higher score for the months prior to admission upon discharge

Conclusion

Katz assessment is effective to identify patients at risk for functional decline. The defined interventions reduced the occurrence of further functional decline in the hospitalized geriatric patient

References

Hoogerduijn, J., Schuurmans, M., Korevaar, J., Buurman, B., & de Rooij, S. (2010). Identification of older hospitalised patients at risk for functional decline, a study to compare the predictive values of three screening instruments. *Journal Of Clinical Nursing*, *19*(9-10), 1219-1225. doi:10.1111/j.1365-2702.2009.03035.x.

Kresevic, D.M. (2012). Assessment of physical function. In A. O'Meara (Ed.), *Evidence-Based Geriatric Nursing Protocols for Best Practice* (4th ed.). New York, NY: Springer Publishing Company.

New York University College of Nursing. (2012). Try this: Katz Index of Independence in Activities of Daily Living (ADL). Retrieved from http://consultgerirn.org/resources.