Rehabilitation Standard
Instrumental Activities of Daily Living

This care standard outlines the process for addressing an individual’s needs in the functional area of instrumental activities of daily living (IADL’s). IADL’s are activities related to independent living and involve interaction with the physical and social environment, generally more complex than personal ADL. IADL activities include but are not limited to:

- Preparing food
- Managing money
- Shopping
- Cleaning house
- Doing laundry
- Accessing public transportation
- Using the telephone
- Gardening
- Doing minor home repairs
- Managing medications

The rehabilitation goal is to ensure that the individual functions as independently as possible in their IADL’s in the environment of his/her choice with or without supports.

Criteria For Referral
Individuals experiencing the following risk factors should be assessed by a healthcare provider:

- Individuals who are unable to complete their own desired role related to IADL safely, independently and without undue effort, and to their satisfaction.
- Individuals with significant changes to their functional status (i.e. CVA, brain injury)

The healthcare provider must obtain informed consent from the individual prior to the initiation of any assessment and intervention.

Screen
Any member of the multidisciplinary healthcare team can complete a screen of IADL function. The screen of an individual’s ability to complete their IADL’s should be initiated on first contact and should include but not be limited to the following:

- Specific IADL tasks the individual needs or wants to do, given living arrangements, roles, culture, etc
- The individual’s satisfaction with performance of IADL
- The supports available to assist IADL (e.g., funding, people, community resources)

If interventions for improvement of IADL functions exceed the healthcare provider’s expertise or knowledge, a referral for an assessment should be made at first contact and clearly documented.

Results of the screen including any recommendations will be documented in the individual’s chart.
Assessment
An assessment should take place when additional expertise is required to address complex IADL needs. The assessment will take into consideration all factors assessed in the screen and may involve a more comprehensive evaluation of the individual’s abilities in order to provide further recommendations or intervention strategies. The assessment should be completed by an occupational therapist, however, if an occupational therapist is not available, it may be completed by another healthcare professional with further training and expertise in assessment of IADL.

An assessment may include but not be limited to the following:
- Observed performance of IADL
- Assessment of the person’s perceived difficulty with IADL performance
- Medical status
- Physical status
- Mental status
- Cognitive-perceptual status
- Psychosocial factors
- Environmental factors that may influence IADL performance.

Plan
The multidisciplinary team members will collaborate with the individual and their family/caregivers to develop a plan that will address the IADL dysfunction.

The expected outcomes are:
- The individual is able to engage in relevant IADL as fully and satisfactorily as possible.
- The individual is able to engage in role supporting behavior.
- The individual has been educated regarding available resources and support systems.

Documentation
The multidisciplinary healthcare team is responsible for documenting the results of assessments, treatment plans and ongoing progress notes regarding the individual’s IADL status. This documentation should be kept in a manner that is accessible to all members of the team using communication tools such as the cardex, care plan, ADL card, or information booklet.

Evaluation
The indicators used to evaluate this standard include outcome indicators based on the individual’s perception of their performance of IADL’s, their goals, and process indicators based on the effectiveness of the standard.

Individual outcome indicators could include:
- Pre- and post- intervention testing with same standardized assessment(s)
- Caregiver burnout/burden of care
- Effective management of medications
- Ongoing individual satisfaction

Process indicators could include:
- Hospital readmission rates
- Cost saved versus daily hospital rate
- Use of home support beyond maintenance of status
- Ongoing literature review update of Best Practices
- Individual audits

If any component of the treatment is to be delegated, the individual will be informed.