NATIONAL INSTITUTE for MEDICAL RESPITE CARE

Addressing Activities of Daily Living (ADL) in Medical Respite/ Recuperative Care

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NATIONAL HEALTH CARE for the HOMELESS COUNCIL

The National Institute for Medical Respite Care is a special initiative of the National Health Care for the Homeless Council.

Objectives

At the conclusion of this webinar . . .

1. Participants will be able to identify activities of daily living (ADL).
2. Participants will be able to identify the definitions of the levels of assistance.
3. Participants will be able to identify the impact of homelessness and health conditions on independence in ADL.
4. Participants will be able to identify strategies to support individuals who are not fully independent in ADL within the medical respite/recuperative care setting.

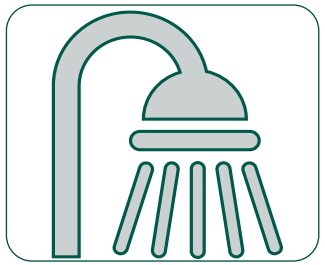
Acknowledgement: This is a complex topic without easy answers!

Activities of Daily Living (ADL):

Activities oriented toward taking care of one's own body and completed on a routine basis.

(AOTA, 2020)

ADLs

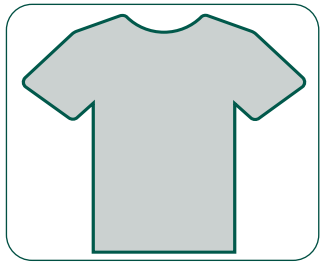


Bathing, Showering

Obtaining and using supplies; soaping, rinsing, and drying body parts; maintaining bathing position; transferring to and from bathing positions.

Toileting and Toilet Hygiene

Obtaining and using toileting supplies, managing clothing, maintaining toileting position, transferring to and from toileting position, cleaning body, caring for menstrual and continence needs (including catheter, colostomy, and suppository management), maintaining intentional control of bowel movements and urination and, if necessary, using equipment or agents for bladder control.



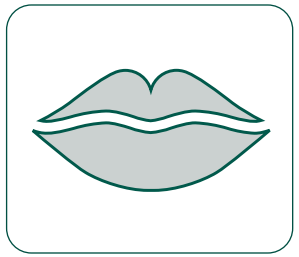
Dressing

Selecting clothing and accessories with consideration of time of day, weather, and desired presentation; obtaining clothing from storage area; dressing and undressing in a sequential fashion; fastening and adjusting clothing and shoes; applying and removing personal devices, prosthetic devices, or splints.

ADLs

Feeding

Setting up, arranging, and bringing food or fluid from the vessel to the mouth (includes self-feeding and feeding others)



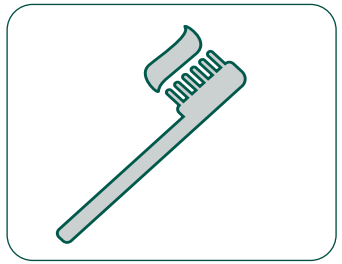
Eating and Swallowing

Keeping and manipulating food or fluid in the mouth, swallowing it (i.e., moving it from the mouth to the stomach)

ADLs

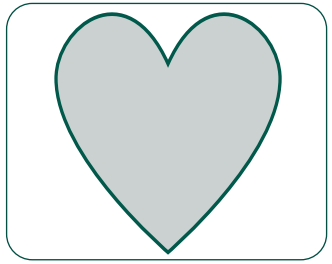
Functional Mobility

Moving from one position or place to another (during performance of everyday activities), such as in-bed mobility, wheelchair mobility, and transfers (e.g., wheelchair, bed, car, shower, tub, toilet, chair, floor); includes functional ambulation and transportation of objects



Personal Hygiene & Grooming

Obtaining and using supplies; removing body hair (e.g., using a razor or tweezers); applying and removing cosmetics; washing, drying, combing, styling, brushing, and trimming hair; caring for nails (hands and feet); caring for skin, ears, eyes, and nose; applying deodorant; cleaning mouth; brushing and flossing teeth; removing, cleaning, and reinserting dental orthotics and prosthetics



Sexual Activity

Engaging in the broad possibilities for sexual expression and experiences with self or others (e.g., hugging, kissing, foreplay, masturbation, oral sex, intercourse)

Factors Impacting ADL Performance

Physical & Medical

Psychological

Cognitive

Environmental

Causes of Limitation in ADL: Physical

Decreased gross and fine motor skills	Pain	Decreased balance
Lack of physical sensation	Tremors	Slowed response rate
Paralysis or hemiparesis	Decreased endurance and activity tolerance	Decreased strength

Causes of Limitations in ADL: Medical

Stroke	Neurological Conditions	Spinal cord injury	Traumatic brain injury
Diabetes	Amputation	Obesity	Arthritis
Decreased vision	Decreased hearing	Neuropathy	Temporary musculoskeletal changes

Causes of Limitation in ADL: Cognitive

- Memory
- Attention
- Executive Function
- Self-awareness
- Problem solving
- Time awareness
- Ability to adapt and generalize

Causes of Limitation in ADL: Psychological

- Decreased initiation
- Decreased motivation
- Disorganization
- Impulsivity
- Decreased cognition
- Trauma and PTSD
- Body image and self-esteem
- Adjustment to new physical or health limitations
- Active substance use
- Active withdrawal from substances
- Acuity of symptoms

Causes of Limitation in ADL: Environmental

- Lack of access to spaces to complete ADL
- Lack of accessibility in spaces to complete ADL
- Lack of access to supplies to complete ADL
- Lack of access to adaptive equipment to complete ADL
- Not enough time to safely complete ADL
- Disrupted routines or inconsistency in ADL resources
- Difficulty self-advocating or navigating needed services

(Abbs et al., 2020; Brown et al., 2019; Simpson et al., 2018)

Impact of Limitations in ADL

Decreased social and community engagement

Stigma and poorer treatment

Exclusion from housing and resources

Falls and fear of falling

Early institutionalization

Increased vulnerability to violence and theft

(Abbs et al., 2020; Brown et al., 2019; Simpson et al., 2018)

Impact of Homelessness on ADL

What do we know from research?

- Disproportionate level of chronic illness and geriatric conditions that can be risk factors for functional impairment
- Premature functional impairment as compared with the general population
- Environmental barriers to engage in ADL affect **all ages**

(Abbs et al., 2020; Brown et al., 2019; Cimino et al., 2015; Fazel et al., 2014; Simpson et al., 2018)

Levels of Assistance:

Describe the amount of support a person needs to complete a task or activity, such as an ADL or an IADL.

(Functional Independence Measure [FIM], 2001)

Levels of Assistance

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.

(CMS, 2017)

ADL in Medical Respite

Factors impacting ADL in respite

Barriers and opportunities to address ADL

ADL in Medical Respite

A mismatch between a person's abilities and their environment results in functional impairment or exacerbates existing impairment

There may be a minimization of supports needed and vulnerabilities to reduce victimization, avoid jeopardizing housing options and minimize risk of institutionalization

Transitions from highly supportive environments to community environments may result in decompensation

- It is not always possible to predict how skills will translate
- The person will not be able to report the "home" environment to hospital providers

(Brown et al., 2019)

Not all ADL are equal . . .

Bathing: Includes bathing the body from the neck down excluding the back (washing, rinsing, drying in tub, shower or sponge bath).

Independent		Does not need help or any modifications.
		Needs assistive device, increased time, or safety issues.
Set-up or clean-up assistance		Needs cuing, coaxing or assistance to set out bathing equipment.
Supervision or touching assistance		Needs incidental assistance such as placement of washcloth (performs >75% of task).
Partial/Moderate Assistance		Needs physical assist bathe one or two areas 50- 74% of task.
Substantial/Maximal Assistance		Needs Maximum physical assist (performs 25-49% of task).
Dependent		Helper performs most/all of the activity <25%
0	Activity Does Not Occur	Enter only for admission assessment. Pt. does not bathe self or is not bathed by helper.

- May need more time to complete ADL
- Reminder to start showering
- Unable to reach specific area of
- Requires other person to wash multiple areas of the body
- Requires person to observe task and provide step by step cuing

Grooming: Includes oral care, hair grooming, washing and drying hands and face, shaving and applying make-up.

Independent		Does not need help or any modifications.
		Needs assistive device, increased time, or safety issues.
Set-up or clean-up assistance		Needs cuing, coaxing or assistance organizing grooming supplies.
Supervision or touching assistance		Needs incidental assistance such as placement of washcloth or help with specific task (performs >75% of task).
Partial/Moderate Assistance		Needs physical assist to groom 50-74% of task.
Substantial/Maximal Assistance		Needs Maximum physical assist (performs 25-49% of task).
Dependent		Total assist; helper provides most of the assistance (performs <25% of task).
0	Activity Does Not Occur	Enter only for admission assessment. Pt. does not perform any grooming activities. (rare)

- Needs adapted fingernail
- Reminder to start grooming
- Cue to ensure has all supplies
- Assistance to squeeze out
- Requires other person to complete majority of task (e.g. unable to cut own toenails)
- Step by step cuing to start and finish task successfully

(FIM, 2001)

Not all ADL are equal . . .

Transfers: Bed, Chair, W/C in both directions. Toilet and Tub are scored separately.

Independent	Does not need help or any modifications.
	Needs assistive device such as grab bar, sliding board or extra time.
Set-up or clean-up assistance	Needs cuing, coaxing or assistance to set up equipment.
Supervision or touching assistance	Needs incidental assistance such as placement of equipment (performs >75% of task).
Partial/Moderate Assistance	Needs physical assist for more than one task or manage equip. 50-74% of task.
Substantial/Maximal Assistance	Needs Maximum physical assist (performs 25-49% of task).
Dependent	Helper performs most/all of the activity and manages equipment <25%
0 Activity Does Not Occur	Enter only for admission assessment. Pt. does not transfer unable to get out of bed. (rare)

- More time to start and finish transfer
- Needs provider to position
- Requires provider to position
- Requires other person to provide physical support of 25 – 50% during movement, such as shifting or lifting

Eating: Includes the use of suitable utensils, bringing food to mouth, chewing and swallowing once presented on table or tray, drinking from cup or glass.

Independent	Does not need help or any modifications.
	Needs assistive device, increased time, safety issues or modify consistency of food.
Set-up or clean-up assistance	Needs cuing or set-up: Help required to open containers, pour liquids, cut food.
Supervision or touching assistance	Needs incidental assistance such as placement of food, or scoop food (performs >75% of task).
Partial/Moderate Assistance	Needs physical assist to eat 50-74% of task.
Substantial/Maximal Assistance	Needs Maximum physical assist (performs 25-49% of task).
Dependent	Total assist; dependent or assist w/ tube feedings (performs <25% of task).
0 Activity Does Not Occur	Enter only for admission assessment. Pt. does not receive any nutrition during assessment. (rare)

- May need non-slip dishes,
- Assistance to have items open
- Person requires assistance for
- May be able to feed self simple items with hands (e.g. toast)
- Requires assistance to manipulate utensils, prepare food for eating

(FIM, 2001)

ADLs and Medical Respite: Barrier or Opportunity?

Requiring independence in all ADL limits admissions of those who may benefit from medical respite	Fills gap in community for those who do not qualify for SNF level of care
Changing level of assistance requirements may blur the lines with referral sources	Provides opportunity for those with changes in functional skills to learn new skills and adapt to changes
Increased assistance means potential for increased safety risk	Address conditions that could further impact functional impairment
Requires an investment in staff and/or equipment	Can be more safe and accessible than other discharge environments

ADL and Medical Respite: Barrier or Opportunity?

- Does the medical respite program have adequate facilities or staffing to support ADL management?
- Are the admission criteria specific to someone who is independent in ADL or could be independent in ADL with equipment or an accessible environment?
- Which ADL could we support if the person needs more assistance? What remains a requirement for independence?
- Is this a health equity need or gap in our community?
- What steps can we take steps to address this within our setting?

Approaches to Addressing ADL

Trauma-informed care

Team collaboration

Engaging the client

Environmental supports

Trauma Informed Care (TIC)

What does TIC look like within ADL?

- Security and privacy within ADL spaces
- Organizing time on the unit for extra and adequate time for ADL
- Discussion of ADL needs in private spaces, address concerns from other residents in private space
- If providing any form of assistance, getting consent prior to providing it (before activity begins or during task)

Understand how difficulty with ADL can cause concerns:

- Fear of losing independence and supports available in medical respite
- Feeling safe and vulnerable in the community
- Facing increased self and social stigma
- Fear of housing loss
- Fear of moving into long-term care facility
- Minimize engagement with social supports or cause social isolation

Addressing Bias

We all complete ADL differently

- We don't want to assume that ADLs are completed in a certain way
- There is not necessarily a "wrong way" to complete ADL
- How do our personal experiences and potential biases view whether or not people are completing "ADL" up to a certain standard?
- Understanding experiences have impacted how a person has developed and implemented their self-care routines

Important to ask our clients what barriers they are experiencing, what about their routines have been disrupted or impacted?

What would their routines look like if current barriers didn't exist?

Team Approach

Communication among the team	Consistency in approaches and strategies	Universal and destigmatizing language regarding what is happening
Ensuring privacy in discussions	Coordinating care between providers	Ensure patient is part of discussions and determining next steps and solutions

Approach: Role of Providers and Staff

Nursing

- Identify and communicate client needs/concerns
- Fall risk assessment
- Support to implement strategies
- Reports need to support transition to appropriate discharge environment

Primary Care and Medical Respite Providers

- Initial exam to identify and address causes
- Referral to appropriate specialists
- Document level of need and supports paperwork to transition to appropriate discharge environment, to access necessary assistive devices, or document disability status

Approach: Role of Providers and Staff

Case Management and Direct Staff

- Identify client needs/concerns
- Coordination of referrals for specialists/medical care
- Support to identify and acquire supplies (if not provided by other providers)
- Navigating available community resources (e.g. accessible transit, food pantries)
- Referral to appropriate discharge placement options

Community Health Worker/Peer

- Identify client needs/concerns
- Support to address concerns at medical appointments
- Navigating available community resources

Behavioral Health

- Motivational interviewing and other strategies to identify concerns
- Address symptoms that may be impacting ADL performance
- Identify and address person's response to change in capabilities

Approach: Engaging the Client

Use motivational interviewing to address concerns and identify person's perceptions of issues, supports needed, and experienced changes.

Questions should be trauma-informed and focus on experience:

- How do you feel about your current self-care routines?
- Is there anything that has changed since you were hospitalized?
- Is there anything making it difficult for you to complete self-care?
- How can we support you while in the medical respite program?

Approach: Assessing Needs
Nursing and PCP/Respite Provider Exam

History	Physical exam
Fall Risk Assessment	Assessment for co-occurring conditions

Approach: Assessing Client Barriers

Assess for other barriers:

- Activity tolerance
- Low vision
- Decreased sensation
- Motivation
- Cognition
- Executive functioning
- Feeling unsafe
- Does the person need increased time?

Duration of assistance:

- Is this temporary as the person heals/recovers?
- Is this permanent and requires long-term change in strategies or adjustment?

Approach: Assessing Needs Additional Tools

Katz Index of Independence in Activities of Daily Living

ACTIVITIES POINTS (1 OR 0)	INDEPENDENCE: (1 POINT) **NO** supervision, direction or personal assistance	DEPENDENCE: (0 POINTS) **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)** Needs 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)** Gets 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 transferring aides 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 = _____ 6 = High (*patient independent*) 0 = Low (*patient very dependent*)

Slightly adapted from 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 Index of Independence in Activities of Daily Living

- Used to detect problems in performing ADL and support care planning
- Option for scoring is yes/no (may not capture nuance)
- Can be supportive documentation to refer for higher levels of care

https://hign.org/consultgeri/try-this-series/katz-index-independence-activities-daily-living-adl

(Hartford Institute for Geriatric Nursing, 2007)

Approach: Strategies to Address ADL Needs

Engage the patient/client

- Identification of strategies that will be used should be developed with and by the patient
- Strategies supported should be acceptable to the person
- When there may be multiple presenting problems, begin with the person's priorities and potential safety risks

Determine staff support

- Identify which staff are appropriate to support any modifications or adaptive strategies, including:
  - Capacity
  - Skills and scope of practice
  - Comfort level of the client

Approach: Individualized Routines & Programs

Establishing a schedule

- Have person complete ADL when they have the most energy or are most alert
- Have the person complete ADL when they are able to take their time and avoid rushing
- Establish a set time to prompt initiation of tasks
- Use a checklist to cue and remember all steps needed to be completed

Assisting set-up of ADL tasks

- Assist person in organizing supplies prior to starting

Verbal or gestural cuing

- Prompt person to use identified strategies
- Prompt at routine times to start ADL

MY DAILY ROUTINES

NAME:

MORNING ROUTINE	M	T	W	T	F
7:00 - Wake up					
7:20 - Hygiene & change clothes					
8:00 - Check sugar & take meds					
8:20 - Breakfast					
Check in with nurse					

EVENING ROUTINE	M	T	W	T	F
7:30 - Shower					
Put dirty clothes away					
8:30 – Get organized for next day					

Set-up space for hygiene

Schedules and space set-up should be at the direction of the client and their preferred routines when possible.

Approach: Individualized Routines & Programs

Organizing personal belongings

- Keep frequently used items in easy to access spaces
- Store items that are used together in one spot
- Minimize bending/reaching

Alternative methods for ADL

- Sink-side bathing
- Using personal wipes/baby wipes
- Dry shampoo/baby powder/ cornstarch

Organize Personal Items

Approach: Individualized Routines & Programs

More accessible clothing options

- Easy to pull on pants (elastic waist or drawstring)
- Shoes without laces (Velcro, pulls, slip-on with a heel)
- Cotton t-shirts that stretch
- Button down shirts (to avoid pulling shirts overhead)
- Adaptive equipment to support dressing can be recommended

Approach: Assessing the Environment

Accessibility and safety of space for ADLs:

- ☐ Are the doors locked? Do people feel safe in the spaces?
- ☐ Are these spaces clean and well-kept?
- ☐ Can a person with physical limitations move safely in the space?
  - Is there room to use needed equipment?
  - Is adaptive equipment available and set-up correctly?
- ☐ Is there space to set-up supplies?
  - Hang a towel and clothes to prevent from getting wet, put items down on sink/countertop?
- ☐ Is there a private and hygienic space to dispose of personal care supplies (menstrual products, depends)?
- ☐ Does the person have access to needed supplies?
- ☐ Are spaces and hallways clutter free and easy to move?
- ☐ Is there adequate lighting?
- ☐ Can the person reach spaces such as the sink or the mirror?
- ☐ Are there supportive and a variety of furniture options available?

Approach: Setting Up the Environment

Accessible Bathrooms

- Shower benches and shower chairs
- Grab bars
- Space to hang clothing and towels within reach
- Non-slip bathmats
- Non-slip shower shoes

Access to sink spaces and hygiene spaces

- Counters and/or shelving to place personal care and hygiene items
- Mirrors and sinks are accessible to range of heights/body sizes

Accessible Shower

- Can the person reach the handle from the chair/seated position to turn the water on and off?
- Is there proper drainage to decrease risk of fall?
- Are there hooks nearby to hang clothes and towels?
- Are there grab bars in appropriate locations?

Accessible Bathroom

- Is there enough space to maneuver and reach needed supplies?
- Is there space to store and lay-out items?
- Are there grab bars in appropriate locations?

Approach: Setting Up the Environment

Support to set-up showering or grooming space to enable independent completion of activity

- Using bag or shower caddy to support organization and ease of carrying items into bathroom
- Support initially to set-up supplies in space and establish ADL routines

Lighting

- Ensure shower and grooming spaces are well-lit
- Ensure pathways are clear and well-lit to access various spaces

Self-care Items

- Increase access and ability to acquire more medically based supplies (mouthwash, specialized soaps, oral care, Depends/continence management, nail clippers, floss)
- Trashcans and places to dispose used products accessible and changed frequently (e.g. including in toilet stalls of communal bathroom spaces)

Approach: Setting Up the Environment

Safe and Accessible Pathways

- Use ADA compliant ramps
- Handrails at stairs, walkways/hallways, and ramps
- Pathways clear of clutter
- Well-lit – can use sensor-based nightlights to support lighting in walkways
- Use ADA compliant doors and handles

Structural Recommendations

- Universal design in spaces
  - Bathrooms
  - Furniture height
  - Variety of furniture/seating options
  - Use door handles or automatic doors instead of knobs

What to do if someone needs more support:

If currently at your program:

- Referral for home health care/home health aid
  - Should include OT and PT to develop and rebuild skills for ADL and identify adaptive strategies
- Referral, assessment, and transition to skilled nursing care
- Referral to available waiver programs for assisted living

Use a TIC approach if offering assistance

- Always ask for consent before providing support or assistance
- Use a strengths-based approach with person as an active participant in their care

What to do if someone needs more support:

Provide assistance ONLY within skills and licensure of your staff and facility

- Training should be completed if any staff are assisting with transfers or minimal or higher level of assistance
- Contact or work with the rehab department at your hospital partners for training
- Have policies, procedures, and training on responses if client experiences a fall and for clients to report misconduct and safety concerns

Staffing Model could include:

- CMA or MA
- Certified home health aid
- LVN, RN
- OT
- PT

Approach: Specialty Referrals

Occupational Therapy

- Evaluation of impact of cognitive, physical, and mental health barriers to engaging in ADL
- Identification of strategies to compensate and complete ADL
- Retraining and practice for ADL
- Recommendations for accessibility and adaptive equipment to perform ADL

Physical Therapy

- Evaluation of physical, musculoskeletal, and neurological barriers to engaging in ADL
- Increase activity tolerance
- Address mobility, balance, stability, and strengthening
- Recommendations for mobility devices
- Recommendations for accessibility

Speech Language Therapy

- Evaluation of cognitive and communication skills
- Identification of strategies to enhance ability to communicate needs or compensate for loss as a result of medical condition
- Address cognitive concerns

Approach: Specialty Referrals

Specialists for Underlying Conditions:

- Neurologist
- Orthopedist
- Ophthalmologist
- Urology
- Rehabilitation medicine
- Psychiatry
- Neuropsych

Behavioral Health

- Address acute stress or mental health symptoms impacting ADL performance
- Address coping and transitioning to new functional abilities or limitations

Approach: Discharge Planning

What is the accessibility of potential discharge options?

- Are they agreeable to pursuing alternatives?

What equipment is needed and can the person potentially use and keep it?

Who is the provider to follow-up on needs, progress, and/or exacerbation of underlying conditions?

Training for the patient to manage completing ADL within shelter or other discharge setting

Approach: Advocacy

Are local shelters accessible?

- Can this be addressed through partnership and training?

What other organizations can provide more support?

- Centers for Independent Living
- Centers on Aging
- Waiver programs for assisted living options

Accessible and affording housing

- How to ensure landlords are fixing and including accessibility features?

Accessibility of skilled nursing and long-term care facilities

- What barriers are experienced by people experiencing homelessness in accessing and receiving quality care in these facilities?
- What can be done to increase use of trauma informed and harm reduction principles in these settings?

Approach: Advanced Training

- Safe patient handling and transfer training
- ADA and accessibility certifications
- ADA Consultant for environmental modification
- Training and Certification in ADL assessment tools

Case Example

Barbara –

- 54-year-old
- Identifies as female
- Referred after hospitalization 2/2 fall, exacerbation of diabetes, and unhealed wound at amputation site. Medical respite goal of healing wound and attending physical therapy appointments.

Medical History

- Left-sided weakness due to a stroke
- Right below knee amputation
- Has been previously unsuccessful in attending PT appointments to fit and safely ambulate with a prosthetic

Social History

- Lost housing during hospitalization for stroke as rep payee did not pay rent
- Is close with cousin, however, cousin lives in inaccessible 2nd floor unit
- Desires to return to independent living

On admission to respite:

- Inconsistent self-report of independence in tasks but also frequently requests assistance from staff and other residents
- Sustained a fall while transferring into the shower while at respite facility (no sustained injury)

Case Example

- What actions could your program take to support Barbara right away?
- What changes might you need to make spaces accessible?
- What screening or referrals could you consider?

https://www.menti.com/kggh1aj19o

Go to Menti.com and enter the code **6849 1500**

Case Example

Assessment

Cognitive assessment

- Revealed mild-moderate cognitive impairment likely result of stroke
- Indicated potential difficulty with planning and problem solving

Behavioral health

- Identified goal to return to living independently, thus reported no need for assistance, but also had significant fears of falling and low stress tolerance for more difficult activities

Interdisciplinary Team Communication

PT mobility assessment and recommendations

OT assessment of ADL and recommended strategies

Support Plan

Practice and use of adaptive strategies

- Transfer training
- Strategies for dressing and bathing

Organization and Verbal Cuing

- Scheduled time to complete showering when more time would be available and staff assistance as needed
- Support to organize space/supplies more effectively & plan ahead for ADL

Final Thoughts and Considerations

What we are not – unlicensed skill nursing facilities for PEH

- Important to look at state and federal guidance on what would classify facility as an assisted living or skilled nursing facility
- May opt to pursue that level of licensing
- Ensure what you are asking staff is within their scope of practice and licensure
- Advanced staff training may be needed
- Important to continue to implement Standards for Medical Respite Programs

Reflection:

- What is the mission of your organization?
- Who are you intending to serve?
- How can we safely adjust to support people in need?

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Questions & Discussion

Related Resources

Clinical Guidelines for Medical Respite/Recuperative Care: Activities of Daily Living
https://nimrc.org/wp-content/uploads/2021/07/Clinical-Guidelines-in-Medical-Respite_-ADL_Final.pdf

Pathways for Incorporating OT Services into Medical Respite/Recuperative Care Programs
https://nimrc.org/wp-content/uploads/2021/07/Pathways-for-incorporating-OT-services-into-medical-respite_final.pdf

Please complete the survey to evaluate today's webinar!
https://www.surveymonkey.com/r/mrrc_1

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Coming Next:

July 14th: Chronic Conditions

July 21st: Managing Incontinence

August: Issue Brief – Levels of Care and Medical Respite

References

Abbs, E., Brown, R., Guzman, D., Kaplan, L., & Kushel, M. (2020). Risk factors for falls in older adults experiencing homelessness: Results from the HOPE HOME cohort study. *Journal of General Internal Medicine, 35*(6), 1813-1820. https://doi.org/10.1007/s11606-020-05637-0

American Occupational Therapy Association. (2020). Occupational therapy practice framework: Domain and process (4th ed.). *American Journal of Occupational Therapy, 74*(Suppl. 2), 7412410010. https://doi.org/10.5014/ajot.2020.74S2001

Brown, R. T., Hemati, K., Riley, E. D., Lee, C. T., Ponath, C., Tieu, L., Guzman, D., & Kushel, M. B. (2017). Geriatric conditions in a population-based sample of older homeless adults. *The Gerontologist, 57*(4), 757-766. https://www.doi.org/10.1093/geront/gnw011

Centers for Medicare and Medicaid Services. (2017). *Proposed measure specifications and standardized data elements for CY 2018 HH QRP notice of proposed rule making*. Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/ Proposed-Measure-Specifications-and-Standardized-Data-Elements-for-CY-2018-HH-QRP-Notice-of-Proposed-Rule-Making.pdf

Cimino, T., Steinman, M. A., Mitchell, S. L., Miao, Y., Bharel, M., Barnhart, C. E., & Brown, R. T. (2015).The course of functional impairment in older homeless adults. *JAMA Internal Medicine, 175*(7), 1237-1239. https://doi.org/10.1001/jamainternmed.2015.1562

Fazel, S., Geddes, J. R., & Kushel, M. (2014). The health of homeless people in high-income countries: Descriptive epidemiology, health consequences, and clinical and policy recommendations. *Lancet, 384*(9953), 1529-1540. https://doi.org/10.1016/S0140-6736(14)61132-6

Simpson, E. K., Conniff, B. G., Faber, B. N., & Semmelhack, E. K. (2018). Daily occupations, routines, and social participation of homeless young people. *Occupational Therapy in Mental Health, 34*(3), 203-227, https://doi.org/10.1080/0164212X.2017.1421491

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