How To try this

CE 2.5 HOURS Continuing Education

By Carla Graf, MS, RN, CNS-BC

The Lawton Instrumental Activities of Daily Living Scale

By detecting early functional decline, the scale can help nurses with discharge planning.

Ed Eckstein

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Overview: Acute illness or a worsening chronic condition can hasten functional decline in older adults. During hospitalization, reduced mobility and other factors may rapidly decrease an older patient's ability to perform activities crucial for independent living, and the effects might be permanent. The Lawton Instrumental Activities of Daily Living (IADL) Scale assesses a person's ability to perform tasks such as using a telephone, doing laundry, and handling finances. Measuring eight domains, it can be administered in 10 to 15 minutes. The scale may provide an early warning of functional decline or signal the need for further assessment. For a free online video demonstrating use of this assessment, go to http://links.lww.com/A246.

Web Video

Watch a video demonstrating the use and interpretation of the Lawton Instrumental Activities of Daily Living Scale at http://links.lww.com/A246.

A Closer Look

Get more information on why nurses should assess for functional decline.

Try This: Lawton Instrumental Activities of Daily Living Scale

This is the scale in its original form.
See page 59.

Georgia Koppel is an 81-year-old widow brought to the ED by neighbors who found her in her yard, wandering and disoriented. (This case is a composite based on my experience.) They reported that Ms. Koppel had a noisy cough and mild confusion earlier in the week. Physical examination and a chest X-ray show dehydration and pneumonia. A Foley catheter is inserted and her urine is dark amber. Her mucous membranes are dry. Anxious, restless, and oriented only to self, Ms. Koppel can't provide a history. Her neighbors say that she lives alone and has no children; they are unsure whether she has any living relatives.

Ms. Koppel is hospitalized; IV fluids, antibiotics, and oxygen are ordered. To begin planning for hospital care and for discharge, the nurse attempts to perform a functional assessment. She asks Ms. Koppel about her ability to perform activities of daily living (ADLs) such as grooming, eating, and using the toilet and instrumental activities of daily living (IADLs) such as managing her finances and arranging transportation. However, Ms. Koppel is disoriented and cannot respond to questions, so the nurse defers the assessment.

THE LAWTON IADL SCALE

Functional assessment instruments measure ADLs and IADLs (see Table 1, page 55). Some also focus specifically on mobility, a crucial aspect of adult independence that is necessary for many ADLs and IADLs.[1] The Lawton IADL scale was developed by Lawton and Brody in 1969 to assess the more complex ADLs necessary for living in the community.[1-3] Competence in skills such as shopping, cooking, and managing finances is required for independent living. Because IADL function is usually lost before ADL function (such as bathing, eating, and using the toilet), assessment of IADLs may identify incipient decline—physical, cognitive, or both—in an older adult who might otherwise appear capable and healthy.[3]

The Lawton IADL scale takes 10 to 15 minutes to administer and contains eight items, with a summary score from 0 (low function) to 8 (high function). (See *The Lawton Instrumental Activities of Daily Living Scale,* page 60.) Each ability measured by the scale relies on either cognitive or physical function, though all require some degree of both.[4] For example, a retrospective analysis by Cromwell and colleagues demonstrated an association between dependence in three items on the scale (using the telephone, self-medicating, and managing finances) and reduced cognitive function in community-dwelling older adults who hadn't been previously diagnosed with dementia.[5] Low scores on other activities, such as housekeeping (a broad category encompassing simple tasks such as washing dishes or mowing the lawn), may more obviously point to problems in physical function.

The scale can be administered with a written questionnaire or by interview. The patient or a knowledgeable family member or caregiver may provide answers. It is appropriate for use with older

Why Assess for Functional Decline?

Functional decline in older adults often begins within 48 hours of hospital admission[6] and may lead to disability, institutionalization, and death. In a study of over 1,250 adults age 70 or older hospitalized for acute illness, Sager and colleagues found that 32% had declined in their ability to perform one or more ADLs by the time of discharge.[7] After three months, 19% of participants reported the loss of an ADL, and 40% reported the loss of an IADL. Many factors contribute to immobility or inability to care for oneself during and after hospitalization[8-12]:

- physiologic and cognitive changes normal to aging
- disease or trauma such as pneumonia or hip fracture
- chronic conditions such as arthritis, diabetes, heart disease, or dementia
- cognitive impairment
- deconditioning resulting from reduced mobility

(For more, see "Functional Decline in Hospitalized Older Adults," January 2006.)

Despite the Joint Commission's mandates for assessment of functional status upon admission and throughout the hospital stay,[13] acute care hospitals use no standard criteria to identify patients at risk for functional decline. Functional assessment screening—using tools such as the Katz Index of Independence in Activities of Daily Living (see "Monitoring Functional Status in Hospitalized Older Adults," page 64) and the Lawton Instrumental Activities of Daily Living Scale—identifies a person's baseline functional status, including some components of mobility, such as the ability to transfer, and documents any changes that take place during hospitalization. Detailed knowledge of a patient's strengths or deficits in self-care and mobility helps nurses plan appropriate rehabilitation both before and after discharge. Systematic functional assessment can also provide information on a patient's response to treatments of acute illness or trauma.

adults admitted to a hospital, a short-term skilled nursing facility, or a rehabilitation facility, as well as with community dwellers. The scale is generally not useful for older adults in long-term care facilities, where residents perform few IADLs without assistance. (For more on the causes and prevalence of functional decline, and the worth of assessment, see *Why Assess for Functional Decline?* above.)

ADMINISTERING, SCORING, AND INTERPRETING THE SCALE

Responses to each of the eight items in the scale will vary along a range of levels of competence—from independence in performing the activity to not performing it at all. It is not necessary to ask the questions in sequence as they appear on the tool. If a patient is talking about shopping for groceries, it is fine to discuss transportation at that time as well. Or the interviewer may first ask "what is your typical dinner?" before asking how the patient prepares meals. If the patient (or other informant) identifies independence with an activity, additional questions are unnecessary. If dependence in an activity is identified, additional information is needed to assess the extent of the deficit and how the deficit is accommodated.

In the late 1960s, Lawton and Brody used the scale to assess all eight domains of function for women but only five for men (food preparation, housekeeping, and laundry were excluded). While current practice is to include all eight domains for members of either sex, it may be useful to remember Ward and colleagues' observation that no IADL scale is right for every person, and "individualizing measures to only those activities which a person needs and wants to perform is a way of ensuring clinical relevance for individuals."[2, 3]

The Lawton IADL scale can be scored in several ways, depending on the goal of the assessment and how the information will be used. Vittengl and colleagues found that the scale had nearly equal validity in a population of rural older adults whether scored with simple or more complex systems.[14] They concluded that, given time constraints, most clinicians will likely choose a faster, easier method of scoring. Based on my clinical experience and reading of the literature (which contains no systematic study of the relative frequency of the use of different scoring methods), the most common method is to rate each item either dichotomously (0 = less able, 1 = more able) or trichotomously (1 = unable, 2 = needs assistance, 3 = independent) and sum the eight responses. The higher the score, the greater the person's abilities.[3, 14] To see the section of the online video that shows nurses administering and interpreting the Lawton IADL scale, go to http://links.lww.com/A247.

Table 1. Comparison of Katz ADLs and Lawton IADLs

Activities of Daily Living (ADLs)	Instrumental Activities of Daily Living (IADLs)
Feeding	Using the telephone
Continence	Shopping
Transferring	Preparing food
Toileting	Housekeeping
Dressing	Doing laundry
Bathing	Using transportation
	Handling medications
	Handling finances

MS. KOPPEL, TWO DAYS IN

Ms. Koppel has now been in the hospital for two days. Her pneumonia is responding to antibiotics and she has been weaned off the oxygen. She continues to have intermittent confusion, which worsens at night, but she usually responds to reorientation. The nursing staff has been able to assess her ADL status. She can perform simple grooming activities such as washing her face and brushing her teeth. However, she needs to be set up at the sink with the items placed in front of her and cued to begin. Her Foley catheter has been removed and she is using the bathroom, with a rare episode of urinary incontinence during the night. She feeds herself when food is placed in front of her; she is able to transfer out of bed when asked to use the toilet. She can ambulate independently but becomes confused and anxious when she walks out of her room into the hospital hallway.

Because Ms. Koppel's physical status has improved and she is more attentive and interactive, her nurse, Rose Applebaum, proceeds with the IADL assessment. Ms. Applebaum sits in a chair next to Ms. Koppel and says, "Ms. Koppel, I have some questions to ask you about how you are managing at home, to see if you might need help with anything when you are ready to leave the hospital. These are questions that we ask all of our patients. Is this a good time to talk?"

"Oh," says Ms. Koppel, "I am doing just fine and don't need help with anything, but you go on and ask your questions."

"Thank you," says Ms. Applebaum. "Please let me know if you get tired and we can take a rest."

To begin, Ms. Applebaum asks whether Ms. Koppel has any formal or informal help at home. Ms. Koppel says that no one helps her but her neighbors always ask if she needs help, as do the people at her church. On Sundays, she adds, she eats lunch at church. Table 2, on page 56, shows the questions, responses, and scoring of Ms. Koppel's subsequent Lawton IADL scale assessment.

Answering the questions makes Ms. Koppel anxious; Ms. Applebaum thanks her and tells her the information she provided is very helpful for planning her care in the hospital and when she is well enough to leave it. Ms. Applebaum is concerned about Ms. Koppel's self-care deficits and what might happen to her if she is discharged to her home without substantial services. She also believes that many of Ms. Koppel's answers are evasive or unclear, and she wants more information to validate what Ms. Koppel is reporting. Ms. Applebaum does not know whether Ms. Koppel's pneumonia is contributing to her altered mental status or whether this is her baseline. The social worker has found Ms. Koppel's closest relative, a cousin who lives in another state; she is flying out to see Ms. Koppel and meet with the team. Ms. Koppel's neighbors have been contacted and will visit her as well. Ms. Applebaum plans to meet with them to corroborate her findings about Ms. Koppel's IADL status.

REASSESSMENTS

In the acute care setting it's likely that only one IADL assessment will be needed, unless the patient has confusion that improves during the hospital stay. In a rehabilitation setting, physical or occupational therapists may assess patients' IADL performance periodically for recovery of function prior to discharge. Many rehabilitation facilities have kitchens and bathrooms set up for patients to demonstrate making coffee or tea, cooking breakfast, doing light housekeeping, using the telephone, and grooming. An occupational therapist may also observe while the patient demonstrates paying bills and handling money. In the community setting, the primary care provider should assess IADLs during office visits, after a hospitalization or acute illness, or when there are any reported changes in physical or cognitive function.

CHALLENGES

Assessment of older adults often requires special considerations. Written materials should be printed in a large font for ease of reading, and the patient's glasses or a page magnifier should be readily available.[15] If using a verbal questionnaire, ensure that the patient is comfortable, the environment is without distractions, and hearing aids or a hearing amplifier are used if needed. Some older adults may need more time to complete the interview. If the assessment requires demonstration of a task such as transferring, walking, or pivoting, provide stand-by

Table 2. Georgia Koppel's Lawton IADL Scale Assessment

Questions	Response	Score and Rationale
"Do you have a telephone at home?" "If you need to make a doctor's appointment, do you use the telephone to do that?" "Do you call friends or your family or receive calls from them?"	Georgia Koppel is evasive about discussing the telephone, doesn't remember the last time she used it, and can't tell Rose Applebaum her telephone number.	**Ability to Use the Telephone: 0** Ms. Koppel's answers suggest she is at the low end of possible responses for telephone use.
"Tell me about shopping for groceries." "How do you get to the store?" "How do you shop for large items like clothes or sheets and towels?"	Ms. Koppel walks down her street to a small store, alone or with a neighbor. She says she has plenty of clothes and can get everything she needs at her local store. She seems confused at the prospect of buying sheets and towels and doesn't answer.	**Shopping: 0** Ms. Koppel is able to shop independently for small purchases only and cannot identify how she would shop for larger or more complex purchases. She is often accompanied by a neighbor for small food purchases.
"What types of food do you like to cook and eat?" "Do you ever cook using your stove?"	She says she doesn't cook much and usually microwaves frozen meals. She doesn't remember using the stove, but sometimes eats at the church or makes or buys sandwiches.	**Food Preparation: 0** Ms. Koppel gives no indication that she is able to cook a more complex meal using the stove.
"Do you have anyone who helps you with household chores, such as cleaning the bathroom or vacuuming?"	Ms. Koppel laughs and says she doesn't need help with cleaning or vacuuming and that she can sweep the floors with a broom.	**Housekeeping: 1** Ms. Koppel's response troubles Ms. Applebaum because of its lack of detail about how she accomplishes these tasks. Ms. Applebaum makes note of this but scores this item in keeping with Ms. Koppel's responses.
"What about laundry; do you do it by yourself?" "Do you have your own washer and dryer?"	Ms. Koppel seems puzzled by these questions and says she uses the sink to wash clothes. She reiterates that "everything is fine" and she doesn't need help.	**Laundry: 1** Ms. Koppel receives a score of 1 even though she seems again unable to provide complete information about how she is performing the task.

Questions (continued)	Response (continued)	Score and Rationale (continued)
"Do you drive your own car? How do you get to your doctor's office?" "Do you take a bus or a taxi, or do you drive?"	Ms. Koppel says that she doesn't drive but that friends from her church pick her up every Sunday for services. She has not been to a doctor in a long time because she never gets sick.	**Mode of Transportation: 0** Ms. Koppel's ability to travel independently or to arrange travel appears extremely limited.
"When you need to take medicines, do you take them by yourself or do you have help with it?"	Ms. Koppel replies that she doesn't take any medicines (except "maybe aspirin for a headache," which she takes on her own).	**Responsibility for Own Medications: 1** As with the housekeeping and laundry items, this category is scored according to responses, although Ms. Applebaum is left with questions about Ms. Koppel's abilities.
"Ms. Koppel, do you pay your own bills, write checks yourself, go to the bank—or does anyone help you with that?"	Ms. Koppel says, "I can't believe how expensive everything is. I don't pay it if it is too much."	**Ability to Handle Finances: 1** As Pearson observes, for some items "a score of 1 . . . does not . . . mean that the highest performance criteria in that item has been met."
		Total: 4 (of a possible 8)

Pearson V. Assessment of function. In: Kane RL, Kane RA, editors. *Assessing older persons: Measures, meaning, and practical applications*. New York: Oxford University Press; 2000. p. 17-48.

assistance or a contact guard, placing your hand on the patient's back or arm for support. If necessary, use assistive devices such as canes or walkers.

When a person has a cognitive impairment such as dementia, explanations should be simple and instructions given in one- or two-part commands. Patients with dementia may mirror your mood; if you are rushed and stressed, they may become agitated. If possible, information obtained from a person with dementia should be corroborated by speaking with family, friends, or caregivers.

Older adults may be reluctant to participate in a functional assessment if they fear losing independence as a result. They may report that their living situation is adequate even if it is not. With all assessments of older adults, Lach and Smith suggest taking a "matter-of-fact approach," establishing rapport and explaining that the questions are a normal part of the assessment.[15] Asking about a typical day can be helpful for starting the assessment, as can highlighting a person's strengths rather than seeming to focus entirely on functional deficits. Emphasize that the goal is to work with patients to create the safest possible discharge plan, which may evolve as they recover, and often a person may be able to remain at home with additional help.

OTHER CONSIDERATIONS

In reviewing the literature on IADL assessment instruments, Ward and colleagues have noted that while "the concept of IADL is generally well understood . . . the content of IADL measures often reflects specific cultural concerns; for example, British measures frequently include the ability to make a cup of tea."[3] They also observe the potential for gender bias, stating that "IADL scales have been said to overemphasize tasks customarily performed by women and so overestimate dependency in men." Dependence in an IADL may in some cases be "situational" rather than functional, as when a widower can shop and prepare food but needs to be taught how to do so after his spouse's death. In a study of cancer patients living at home, about half of the help in IADL tasks received by married men was attributable not to functional deficit but to their perceptions that those tasks were "women's work."[16]

Watch It!

Go to http://links.lww.com/A246 to watch a nurse assess an older adult's functional status and discuss how to intervene when abilities are compromised.

View this video in its entirety and then apply for CE credit at www.nursingcenter.com/AJNolderadults; click on the *How to Try This* series link. All videos are free and in a downloadable format (not streaming video) that requires Windows Media Player.

Members of different groups may respond differently to an item on an instrument even though they may have the same disability level. Research using the Lawton IADL scale was tested to identify the extent of item-response bias in a sample of 1,072 noninstitutionalized adults age 60 and older in Singapore.[17] "Given the same level of functional status, older elderly were less likely to report needing help with preparing meals than younger elderly; men were more likely to report needing help with preparing meals, doing laundry, and taking medication than women," reported Niti and colleagues. The impact of item-response bias "on group differences in cognitive IADL was highest for ethnicity (58%), followed by gender (50%), and dementia (23%)." The authors recommend keeping in mind the potential effect of item-response bias when comparing disability status among population groups by age, ethnicity, sex, dementia, or other socioeconomic factors.

MS. KOPPEL: GATHERING INFORMATION

Ms. Koppel's cousin, Claire Webber, has arrived and has visited Ms. Koppel's home. Ms. Webber has not seen Ms. Koppel since she retired and moved out of state about nine months ago; before then, they saw each other frequently. She now meets with Ms. Applebaum and provides information about how Ms. Koppel has been living. Ms. Koppel's home, she says, is unkempt and has not been maintained for some time. There are stacks of bills. There is little food in the pantry and refrigerator. Ms. Koppel has not paid the telephone bill, and the phone has been disconnected. Ms. Webber has not yet had time to review Ms. Koppel's bank records, but there are overdraft notices in the mail. Ms. Webber also reports that Ms. Koppel's mental state is not her usual one, and she has never seen Ms. Koppel confused before.

Ms. Koppel's neighbors also visit the hospital and speak with Ms. Applebaum. They have never been in her home, they say, but they describe finding her mildly confused more frequently of late, with her confusion worse in the evening. Even so, they say, she always "returned to normal after a little conversation." They also report that Ms. Koppel had stopped going to church every Sunday and rarely left her yard.

COMMUNICATING THE RESULTS

During rounds the morning after Ms. Koppel's Lawton IADL assessment, Ms. Applebaum informs the physicians and social worker on her team of her findings, the information she's gathered about Ms. Koppel's home life, and her concerns for Ms. Koppel's safe discharge. A referral is made for physical and occupational therapy evaluations to provide additional information for discharge planning.

Diagnostic work-up has also revealed that Ms. Koppel has cerebrovascular disease and has likely had small strokes prior to admission. Although not physically disabling, the strokes may have left her with cognitive impairment, as suggested by the results of a Mini-Cog assessment (see "The Mini-Cog," December 2007), which included a deficit in three-item recall and an abnormal clock drawing. Since it is uncertain how much of her prior cognitive function she will recover, the team believes it is unsafe for Ms. Koppel to return home alone. The plan, which is discussed with Ms. Koppel and Ms. Webber, will be to transfer Ms. Koppel to a skilled nursing facility for rehabilitation, including physical and occupational therapy. Although Ms. Koppel is anxious about the transfer, her cousin's presence comforts her, and she agrees to it. This rehabilitation period will give Ms. Koppel and Ms. Webber time to plan Ms. Koppel's future—possibly in an assisted-living or board-and-care facility—while giving her time to recover function.

To watch the portion of the online video in which nurses discuss the skills needed to live independently, go to http://links.lww.com/A248.

CONSIDER THIS

What is the evidence supporting the use of the Lawton IADL scale in clinical practice? There are over 200 instruments that measure physical function, including approximately 50 for assessing ADLs. In addition to instruments that measure ADLs and IADLs, some scales measure advanced ADLs (known as AADLs), including exercise, leisure activities, work, travel, hobbies, volunteering, or participation in religious or social activities. Many instruments lack information on reliability and validity and have not been formally tested, making comparison difficult.

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The Lawton Instrumental Activities of Daily Living (IADL) Scale

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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.

THE LAWTON INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE

Ability to Use Telephone

1. Operates telephone on own initiative; looks up and dials numbers 1
2. Dials a few well-known numbers 1
3. Answers telephone, but does not dial 1
4. Does not use telephone at al 0

Shopping

1. Takes care of all shopping needs independently 1
2. Shops independently for small purchases 0
3. Needs to be accompanied on any shopping trip 0
4. Completely unable to shop 0

Food Preparation

1. Plans, prepares, and serves adequate meals independently 1
2. Prepares adequate meals if supplied with ingredients 0
3. Heats and serves prepared meals or prepares meals but does not maintain adequate diet 0
4. Needs to have meals prepared and served 0

Housekeeping

1. Maintains house alone with occasion assistance (heavy work) 1
2. Performs light daily tasks such as dishwashing, bed making 1
3. Performs light daily tasks, but cannot maintain acceptable level of cleanliness 1
4. Needs help with all home maintenance tasks 1
5. Does not participate in any housekeeping tasks 0

Laundry

1. Does personal laundry completely 1
2. Launders small items, rinses socks, stockings, etc 1
3. All laundry must be done by others 0

Mode of Transportation

1. Travels independently on public transportation or drives own car 1
2. Arranges own travel via taxi, but does not otherwise use public transportation 1
3. Travels on public transportation when assisted or accompanied by another 1
4. Travel limited to taxi or automobile with assistance of another 0
5. Does not travel at all 0

Responsibility for Own Medications

1. Is responsible for taking medication in correct dosages at correct time 1
2. Takes responsibility if medication is prepared in advance in separate dosages 0
3. Is not capable of dispensing own medication 0

Ability to Handle Finances

1. Manages financial matters independently (budgets, writes checks, pays rent and bills, goes to bank); collects and keeps track of income 1
2. Manages day-to-day purchases, but needs help with banking, major purchases, etc 1
3. Incapable of handling money 0

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

Lawton, M.P., & Brody, E.M. (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. *The Gerontologist, 9*(3), 179-186.

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Few studies have tested the psychometric properties of the Lawton IADL scale, although it has been used for almost 40 years. Lawton and Brody originally determined acceptable levels of interrater reliability and construct validity for the Lawton IADL scale by examining its correlation with other scales that measure functional competence.[2]

Reliability. Little is known about the reliability of the Lawton IADL scale, other than the information given in the original report by the developers of the scale.[2] Interrater reliability was determined with a sample of 12 subjects. One rater administered the assessment to the subjects while a second rater was present but did not interview the subjects; correlation between the two ratings was 0.85. (The version of the scale tested for male subjects included only five items, with housekeeping, cooking, and doing laundry excluded.) The reproducibility coefficient (reproducibility is "the ability of the test to produce consistent results when repeated under the same conditions"[18]) was 0.96 for men and 0.93 for women (n = 97 and n = 168, respectively).

Validity was originally tested using a sample of 180 subjects who were given the Lawton IADL scale and up to four additional tests that measured different domains of functional status: self-care activities, physical health and mental health, and behavioral and social adjustment.[2] The correlations between the IADL scale and the other measures of functional status ranged between 0.40 and 0.61.

Sensitivity and specificity. A literature search turned up no published reports on the sensitivity and specificity of the Lawton IADL scale.

The Lawton IADL scale is an appropriate tool for use with older adults in acute care, rehabilitation, and outpatient settings. The strength of this tool is its ability to measure more complex levels of function than an ADL instrument; since a person is likely to lose the ability to perform complex activities before losing the ability to perform simple activities, the Lawton IADL scale is likely to be more sensitive in detecting earlier, less severe dysfunction. However, because it uses a questionnaire rather than observation of actual performance, the patient, caregiver, or family member who is interviewed or who fills out the questionnaire may over- or underestimate an ability.[19] It is also important to remember that the Lawton IADL scale is only one part of complete functional screening for older adults. ▼

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Routine use of a Try This *tool or approach may require formal review and approval by your employer.*

Online Resources

For more information on this and other geriatric assessment tools and best practices go to www.ConsultGeriRN.org—the clinical Web site of the Hartford Institute for Geriatric Nursing, New York University College of Nursing, and the Nurses Improving Care for Healthsystem Elders (NICHE) program.

Visit the Hartford Institute site, www.hartfordign.org, and the NICHE site, www.nicheprogram.org, for additional products and resources. For example, on the Hartford site you will find an interactive clinical vignette called "Geriatric Syndromes—Falls and Nutrition/Fluids" that includes use of the Katz ADL and Lawton IADL tools.

Go to www.nursingcenter.com/AJNolderadults and click on the *How to Try This* link to access all articles and videos in this series.

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