Aged care case study - theories of ageing

Clinical Speciality Assignment – Aged care related case study.

INTRODUCTION:

For privacy through this case study the writer will refer to the patient as Mrs A. This case study will investigate the health condition of Mrs A. Mrs A is 82 years old and has lived with Parkinson's Disease for the last 20 years. Mrs A is currently taking Levodopa, Atanol and Lepitol. Mrs A's symptoms have got progressively worse as she has aged. Things that she used to be able to do are now a lot more difficult for her, even simple things like getting out of chairs, walking without shuffling her feet and keeping her balance. This case study will research different theories of ageing and how these relate to the health condition that Mrs A is suffering from. Models of care will be discussed as well as the best model of care to suit Mrs A and why this model of care would be the most suitable option for Mrs A. This case study will also look at a management plan for Mrs A to improve her quality of life through different interventions and strategies. This will include set review times to make sure Mrs A is getting the most out of the management plan. Finally this study will research the legal and ethical issues that could impact Mrs A.

Parkinson's is the second most common neurodegenerative disorder, characterised by both motor and non-motor symptoms. The four main motor symptoms of Parkinson's disease are: Shaking or tremor, slowness of movement (Bradykinesia), stiffness or rigidity of the arms, legs and trunk, trouble with balance (postural instability)(Levy, pp. 1242-1246).

CASE STUDY – MRS A

For this case study we will be researching the condition of an 82 Year old woman with a diagnosis of Parkinson’s disease. Mrs A was diagnosed with Parkinson’s disease in her early 60s. She currently takes Levodopa, Atanol and Lepitol. She lives with her husband who is ?? years old and in generally good health. Mrs A is the one who prepares the meals and does the housework at home. But as the disease and symptoms have progressed, it is getting increasingly difficult for Mrs A to continue these activities without help from her husband. She had been pretty healthy before her diagnosis, she was born in England moved to Australia when she was ?? years old. She did suffer from pneumonia twice and had a fall while crossing a road before her diagnosis but other than that she was a healthy woman. The diagnosis came as a big shock to Mrs A and she went through a range of emotions, including denial. Unfortunately due to the denial she was suffering from this delayed her in seeking the help and medication she needed, which means Mrs A didn’t start any medical intervention as soon as she was diagnosed. Mrs A ended up starting medical intervention due to her daughter taking her to appropriate appointments and convincing her that this is what she needed to help Mrs A maintain her quality of life. Mrs A currently takes Levodopa 4 times a day to treat the symptoms of Parkinson’s and has been taking this for the last 20 years. Mrs A states that the Levodopa still works well for her symptoms. Despite taking her medications, Mrs A still currently suffers from a range of symptoms such as the tremor, rigidness, stiffness, difficulty walking, getting up and down, speaking, memory, tiredness, lethargy. These conditions have progressed as her age progressed. Mrs A develops risk factors for a lot of other conditions due to her Parkinson’s symptoms such as falling, choking, aspiration, etc. It is important for Mrs A to be able to still

enjoy and have a good quality of life. This will require a management plan and review of the plan to monitor its effectiveness.

THEORIES OF AGING:

Parkinson's disease is an age-related disease due to an age-associated increase in oxidative damage to the brain. Dopaminergic neurons decrease at a rate of 5-10% every ten years in normal aging; yet the rate and intensity of neuronal decrease in patients with Parkinson's disease is a lot more than that of just aging.(Kumar et al., pp. 478-504) Most theories of aging can fall into two different categories, programmed and damage/error theories.(Jin, pp. 72-74) The programmed theory implies that ageing is already genetically programmed to occur with time and slowly deteriorates until death where as the damage theory is the idea that external or environmental forces gradually damage cells and organs, leading to aging and death. Individual damage theories focus on how a slow and continuous damage to cells will eventually lead to cellular dysfunction. Damage theories do not rely on a pre-determined timeline for aging and infer that we could possibly increase our lifespan if we take steps to protect our bodies from cellular damage.(Jin, pp. 72-74) Free radicals are also associated with aging. " The free radical theory of aging states that we age because of free radical damage over time,"(Szalay, p. 1)

IMPLICATIONS OF THESE THEORIES ON THE HEALTH OF MRS A:

Due to the implications of Parkinson's disease, this disease relates to the programmed theory of aging due to the fact that there is no known external environmental factors that causes Parkinson's disease. It is unknown what

causes Parkinson’s disease but what is known is that the body internally stops producing dopamine causing many of the symptoms of Parkinson’s disease.

Free radicals are fast growing cells in the body that are associated with human disease, including cancer, atherosclerosis, Alzheimer’s disease, Parkinson’s disease and many others.(Szalay, p. 1) Things that can produce free radicals are found in the food we eat, the medicines we take, the air we breathe and the water we drink.(Szalay, p. 1) This part of Parkinson’s disease seems to back up the Damage theory. If free radicals overwhelm the body’s ability to regulate them, a condition known as oxidative stress occurs. Free radicals negatively alter lipids, proteins, and DNA and trigger a number of human diseases including Parkinson’s disease.(Lobo, Patil, Phatak, & Chandra, pp. 118-126) Free radicals are created either from normal essential metabolic processes in the human body which support the Programmed Theory of aging or from external sources such as exposure to X-rays, ozone, cigarette smoking, air pollutants, and industrial chemicals which supports the damaged theory of aging.(Lobo et al., pp. 118-126) The symptoms of Parkinson’s Disease are only detected once 50% of the nigral neurons and 80% of the striatal dopamine are already permanently lost.(Kumar et al., pp. 478-504) There is currently still no answer for the ongoing question, what specific age related factors predispose certain individuals to develop this common neurodegenerative disease?(Reeve, Simcox, & Turnbull, pp. 19-30)

MODEL OF CARE:

There are three main models of care, Consumer directed care which is a financial model of care and two clinical models of care which are the Eden Alternative model and the Person centred care model. For Mrs A, the person centred care model would be most beneficial as this model of care involves treating not the physical care of the patient alone but the whole person, including their social, cultural and individual identity requirements.(martin & Mills, pp. 22-29) This would be most appropriate for Mrs A as her health condition, Parkinson's disease effects more than just the physical body of the patient, it also affects the way the person thinks about themselves, the way they think about life, it causes depression in 90% of people with this condition and also affects the friends, family and loved ones of the person with the illness.(Anderson, pp. 323-332) Patient centred care is important in making Mrs A feel like she is not alone and she is still has control of her life and what happens to her. This model of care will be able to cater for Mrs A helping to make decisions together with the medical team and not just have decisions made without any input from her. This makes the patient feel heard, in control, respected and takes away a little bit of the isolation associated with this disease.(Kittle, pp. 4-6) There are also other symptoms that aren't as easily seen as the physical ones. A lot of people feel embarrassed about their disease and therefore will not talk about their condition and attempt to hide it.(Anderson, pp. 323-332) Mrs A did this for a while before her diagnosis by holding the arm that was shaking due to embarrassment, a lack of acceptance in the community and lack of understanding about her condition.

MANAGEMENT PLAN FOR MRS A:

Mrs A is currently taking Levodova 4 times a day for her Parkinson’s she feels like this is still going well and states that she does not feel like it is wearing off. Mrs A would benefit from a medication review from her doctor to make sure she is getting the most out of her medication plan. Mrs A and her husband go for walks everyday to keep themselves active, which is excellent to help Mrs A’s condition. Mrs A should also be referred to a physiotherapist to learn more specific exercises that relates to improving her condition and minimising symptoms. The physio will also be able to aid Mrs A with gait and balance training protocol with strength training, as this has found to be effective in reducing falls up to 6 months after the intervention.(Skelly, Lindop, & Johnson, pp. 10-14) Strength training is a fairly new intervention for Parkinson’s suffers but recent studies have shown a long-term reduction in motor symptoms based on progressive resistance training twice every week. (Pinter, pp. 123-130) There is increasing evidence that the effective care of patients with Parkinson’s disease should involve a multidisciplinary team of health professionals, including the neurologist, Parkinson’s disease nurse specialist, physiotherapist, occupational therapist, speech and language therapist, dietician, clinical psychologist and social worker(Skelly et al., pp. 10-14) Mrs A has not been offered any of these services yet. It is important that Mrs A gets referrals to all important services so it is ensured she is living the best possible quality of life. This includes a referral to a psychologist as treatment of behavioural symptoms in Parkinson’s disease is just as important to treat as it can greatly improve a patients overall function and quality of life.(Anderson, pp. 323-332) A referral to a physiotherapist to help improve gait, balance, improve aerobic activity, movement initiation and increase independence. Occupational therapist to give help on

maintaining activities of daily living, with the aim of maintaining friendships and family relationships, encouraging self-care, assessing any safety concerns, cognitive assessments and arranging any appropriate interventions. Speech and language therapist to improve Mrs A's loudness and speech, ensure any methods of communication are offered as the disease progresses. Mrs A could also benefit by seeing a dietician to review her meals and if she may be having any issues when eating or drinking.

Mrs A will also need a referral to a continence advisor as she has recently disclosed that she is having trouble making it to the toilet. She is very embarrassed about this and does not like to discuss it. Encourage Mrs A to take warm baths and massage the muscle for stiffness and muscle weakness. Teach Mrs A to use facial exercises and breathing methods to correct the words and volume when she is speaking, this is to increase her potential to communicate effectively due to the decline in speech and facial muscle stiffness. Educate Mrs A on deep breath before speaking to increase the volume and number of words in sentences of each breath.(NANDA, pp. 1-2) The National Institute for Health and Clinical Excellence suggests specialist review every 6-12 months.(National Institute for Health and Clinical Excellence, p. 53)

LEGAL AND ETHICAL ISSUES THAT NEED TO BE CONSIDERED FOR MRS A:

-reported difficult ethical tensions between safety and autonomy

The balance of safety and autonomy, conceptualizing home care as maintaining independence rather than accepting dependence.(Denson, Winefield, & Beilby, pp. 2-12)