

Patient suffering with a long term health problem essay sample

[Health & Medicine](#), [Hospital](#)



The care and management of patients suffering with a long term condition is an integral part of the nurse's role. With approximately 15 million people in the UK suffering from at least one chronic illness (DoH, 2012), it becomes apparent why the Department of Health (DoH) and the National Health Service (NHS) have had to put in place advice and guidelines in order that the appropriate measures are taken to ensure that these patients are cared for in the most productive way. This essay is going to discuss the issues that are associated with long term conditions and chronic illness. The focus of this discussion is going to be a case study on a patient who is currently an inpatient in an intermediate care setting. To maintain patient confidentiality, the patient will be known as Mrs P for the sake of this essay. The patient in question is an 84 year old lady who lives with her 86 year old husband in a small semi-detached house (See attached appendix for a full history of Mrs P). Mrs P was initially admitted in to hospital after a succession of falls in a short proximity of time and has since been newly diagnosed with Parkinson's disease.

Parkinson's disease is a degenerative neurological disease effecting the neurons within the brain (Lang et al, 2001). The main symptoms that sufferers experience are tremors, rigidity and slowness of movement. Other symptoms can include pain, fatigue, constipation and depression (Parkinson UK, 2012). For Mrs P, the symptoms that she experienced were closely associated with her ability to move safely which resulted in the falls that occurred. For this reason, the topic of mobility as an actual problem and falls being the potential problem has been identified and has been chosen as an area of focus in relation to Parkinson's as a long term condition. To be able

to analyse this discussion, a model of nursing will be used which in this case is Roper, Logan and Tierney's activities of daily living (1998). The Department of Health states that 'Chronic Diseases are diseases, which current medical interventions can only control, not cure. The life of a person with a chronic condition is forever altered- there is no return to normal' (DoH, 2004).

People as a whole tend to live longer, so it is unsurprising that more and more people are suffering with a long term medical condition that they will have to live with for the remainder of their lives. We as nurses need to have the knowledge and skills to be able to successfully manage these conditions and to assist our patients to have the best quality of life possible. The department of health has set up a series of frameworks in order to ensure that quality requirements are met within the NHS and Social Services. These frameworks are called National Service Frameworks (NSF) and have been put in place as guidelines to reduce differences in the treatment, care and support that patients receive (DoH, 2005). The NSF for long term conditions was published in 2005 and consists of ten main aims which include: services which are easier to use and more closely matched to people's needs; ensuring that services are better at helping people with neurological conditions and their carers to make decisions about care and treatment; Giving people with long-term neurological conditions better results from their treatment and assisting people to carry on living independently (DoH, 2005).

This framework also plays a key role in ensuring that patients with a suspected neurological disease are diagnosed as quickly as possible so that

the appropriate treatment can be commenced. In the case of Mrs P, her symptoms did suggest that she may have Parkinson's disease therefore it was vital that the diagnosis was made as soon as possible. For Mrs P, the time frame from the beginning of the symptoms to a diagnosis of Parkinson's disease was three weeks. However, before a formal diagnosis was made, the drug treatment, madopar, was prescribed and administered to assess if this drug had a positive effect on the patient therefore suggesting that she was in fact suffering with Parkinson's disease. Research suggests that if a significant clinical improvement has not been achieved after a period of four to eight weeks then it is unlikely that a diagnosis of Parkinson's will be made (Hou, Lai, 2008). In this case, the drug treatment did in fact have a positive effect on Mrs P's symptoms therefore a diagnosis of Parkinson's Disease was reached. Mrs P suffers from two chronic conditions which are hypertension and Parkinson's disease.

The Parkinson's disease was diagnosed three weeks ago after Mrs P was admitted in to hospital following three falls that occurred over a 48 hour time period. Parkinson's disease is a common, chronic, progressive neurological condition, estimated to affect 100-180 people per 100, 000 of the population and has an annual incidence of 4-20 per 100, 000. There is a rising prevalence with age and a higher prevalence and incidence of Parkinson's in males (NICE, 2006). Parkinson's disease primarily affects the neurons of the brain area known as the substantia nigra or 'black substance' which is a small area located deep within the brain, bilaterally. When these neurons degenerate, it disrupts the ability of the brain that is associated with

movement which in turn causes the symptoms and signs that are characteristic of Parkinson's disease, for example, tremor; rigidity; akinesia and bradykinesia (Lang et al, 2001). Electrical and chemical events occur within the brain that transmits information from one neuron to another using a chemical called a neurotransmitter. The neurotransmitter that is used by the substantia nigra is called dopamine (Dawson et al, 2005).

When the cells contained in the substantia nigra die, the dopamine levels subside therefore leaving any messages that are usually relayed to other motor centres using dopamine unable to get through. This action is the primary cause of the motor symptoms related to Parkinson's (Dawson et al, 2005). There are two pathological hallmarks that are found in Parkinson's disease. These are the loss of dopaminergic neurons within the substantia nigra and the presence of Lewy bodies (Swinn, 2005). The Lewy bodies are specific to Parkinson's disease when they are distributed however they can also be found in other neurological diseases such as motor neuron disease and supranuclear palsy (Gibb and Lees, 1988). Although the exact purpose of the Lewy body is yet unknown it has been suggested that perhaps it may assist with the elimination of the damaged proteins from cells (Swinn, 2005). For Mrs P, the symptoms of Parkinson's disease have greatly affected her ability to mobilise safely resulting in a number of falls occurring in her own home.

Postural instability is deemed a cardinal feature of Parkinson's disease and causes unsteadiness when walking and standing (Roberts and Overstall, 2008). The ability to mobilise is something that for most people is a natural

daily occurrence. Horak and King (2009) describe mobility as 'the ability of a person to move safely in a variety of environments in order to accomplish functional tasks'. Being able to control one's own mobility requires sensorimotor agility involving the coordination of a complex sequence of movements, a constant evaluation of environmental cues along with the ability to switch motor programs when conditions change within the environment (Horak and King, 2009). The effects concerning mobility that Mrs P has experienced are common for people with Parkinson's disease. For example, as Mrs P described, she noticed a very gradual difference in her ability to walk and the movements of her body did not appear as fluid as they once were. Initially, Mrs P did not feel that this was a major problem and put it down to having a few "off days". However, as in the case of Mrs P, sufferers of Parkinson's disease tend to increasingly slow down their walking pace over time.

This in turn can lead to the patient walking in such a way that makes it difficult to raise their feet far from the ground thus resulting in shuffling style of movement (Lang et al, 2001). Mrs P has adopted this style of walking and now finds it more productive to walk with the aid of a frame. However, as effective as this may be whilst Mrs P remains in hospital, it does bring about the issue of mobility when discharge occurs. For example, the layout, furnishings or contents of Mrs P's home may be problematic for the use of a walking aid therefore it will be vital that a full occupational therapy visit and assessment takes place prior to discharge to assess the living conditions and ensure that Mrs P will be able to mobilise effectively. Before actual mobilising

can take place, it is important to consider Mrs P's ability to transfer from a seated position to standing in order to begin walking. Her ability to stand still appears to be unchanged although she does have some trouble to transfer from a sitting position to a standing position.

This may be due to stiffness in the joints caused by Parkinson's but it is also important to take in to account Mrs P's age as this may also be a contributing factor to her inability to move into a standing position. Mrs P also experiences a degree of freezing when attempting to mobilise. Freezing, or sudden cessation of walking, generally occurs either while turning or when the patient is confronted by an environmental factor such as a doorway (Bishop et al, 2008). The most common type of freezing is a hesitation to start, also known as gait ignition failure. The patient attempts to begin to walk, however their feet remain stuck to the floor (Overstall and Roberts, 2001). This is relevant to Mrs P and has happened on numerous occasions whilst on the ward. She appears to hesitate whilst trying to take the first step and she sometimes takes several short incomplete steps before she is able to move forwards. With mobility being the actual problem for Mrs P, this then brings in the potential problem which in this case is falls. Every five hours an older person is killed by an accidental fall in the home - this is the equivalent to 1, 500 people dying every year.

Over 300, 000 older people are so seriously injured by a fall in their home that they require hospital treatment (Age UK, 2012). However, people with Parkinson's disease are twice as likely to be recurrent fallers compared to other older people (Allen et al, 2009). In Parkinson's disease, falling is usually

the result of impaired postural reflexes or freezing of the upper trunk or lower body (Rodnitzky, 2000). Most falls occur within the home whilst trying to turn or transfer from bed to chair (Overstall and Roberts, 2001). As already mentioned, Mrs P fell three times in 48 hours, thus resulting in her admittance into hospital. Each fall occurred whilst she was walking or transferring therefore it is imperative that appropriate measures are present to prevent further falls from happening. The NICE guidelines for the assessment and prevention of falls in older people (2004) has some key priorities for implementation in place to aid with the assessment of patients who are at risk of falling with the goal to help prevent initial or recurrent falls from transpiring. The guideline suggests that a multifactorial assessment should be carried out on older patients who have required medical attention for a fall or who have suffered recurrent falls in the last year.

This includes assessments of gait, balance and mobility, and muscle weakness; osteoporosis risk; assessment of the older person's perceived functional ability and fear relating to falling; visual impairment; cognitive impairment and neurological examination and assessment of home hazards (NICE, 2004). By completing this assessment, healthcare professionals are better equipped to be able to understand the possible cause of the patients fall and also identify potential hazards that may arise and hopefully prevent the incident from reoccurring. Some of the key points highlighted in the NICE guidelines can be related to Mrs P. For example, after her second fall, she discussed how she was fearful of falling again resulting in her anxiety levels increasing when mobilising. This may have had a detrimental effect on her

confidence to mobilise safely therefore it cannot be ruled out that the third fall may have been down to a lack of confidence and increased anxiety rather than being connected to her Parkinson's. Although Mrs P is 84 years old, she has maintained an independent lifestyle throughout her later life.

Her husband was diagnosed with having Parkinson's disease 2 years ago and has been heavily reliant on his wife for assistance with day to day tasks that he is now unable to carry out. With this mind, it becomes apparent how much Mrs P's diagnosis of Parkinson's disease and its relevant issues will affect both herself and her husband's ability to successfully carry out the activities of daily living as described by Roper, Logan and Tierney (1998).

Roper et al (1998) describe a model of living consisting of 12 activities that collectively contribute to the complex process of living. In the case of Mrs P, there are five of these activities that are affected by her long term condition. The first is maintaining a safe environment. As illustrated by Roper et al (1998), the process of ageing inevitably affects the ability to maintain a safe environment all of the time without the need of preventative measures or aids of some sort. Mrs P has become increasingly aware of the danger of her surroundings and the hazards that may be present which is perhaps something that had not been an issue for her previously. Mrs P is also aware of her need to depend on others recently which is something that she is not comfortable with as she has always been very independent.

This in turn has had a psychological impact and she has become quite depressed and upset by the circumstances that she has found herself in.

However, it should be noted that her depression may be a side effect of the

medication she is currently taking for the Parkinson's although this and the combination of events is likely to have increased her depressive state further. This follows on to the next activity of communicating which is an integral part of all human behaviour (Roper et al, 1998). However, old age alone can bring about vision and hearing impairments which can greatly affect a person's ability to communicate successfully. It is not only sensory distortions that can affect a person's ability to communicate. For example, many people often rely on hand gestures and facial expressions to add emphasis and meaning to their words. For sufferers of Parkinson's disease this can become extremely challenging due to a number of symptoms that are common with the disease such as a loss of facial expression, reduced spontaneous gesturing and a reduced volume of speech (Lang et al, 2001). Mrs P has begun to show a varying degree of these symptoms with the most prominent being her lack of facial expression. She tends to stare and her face is almost mask-like in appearance.

This along with her decreased level of volume in her voice has had a detrimental effect on her level of communication, however these symptoms could also have had psychological consequences. Mrs P may be feeling frustrated that she is unable to communicate her needs and wishes with her family and also the staff at the hospital therefore potentially leading to further bouts of depression. Perhaps the most relevant activity of daily living for Mrs P is mobilising. It also has a close link to the previous point in that the ability to communicate is virtually impossible without movement (Roper et al, 1998). As previously stated, speaking, eye movement and facial

expression are all factors associated with Parkinson's disease and are symptoms that Mrs P suffers with on a daily basis. Mrs P's physical decline in her ability to mobilise is fairly apparent thus resulting in her dependence on walking aids which is not something that she was reliant on before. However, it is important to remember that Mrs P was the primary carer for her husband before her admittance to hospital therefore it becomes significant that Mrs P's ability to carry out the activity of mobilising for herself has a follow on effect on her husband's dependence on his wife.

This then brings up concerns for the safety and welfare of both Mrs P and her husband after discharge and is a matter that the multidisciplinary team will need to address prior to Mrs P being discharged from hospital. The inability to successfully mobilise can also affect a person's capability to attend to their own personal care needs. 93% of Parkinson's disease sufferers have noted problems with walking and mobility with over a third needing help with personal care at least some of the time (Lloyd, 2003). When Mrs P was first admitted in to the acute care setting she struggled to maintain her independence in washing and dressing herself. When asked about this, Mrs P said that she lacked confidence in her own ability to manoeuvre herself into a position where she felt safe enough to be able to carry out those tasks. To address this issue, staff primarily assisted Mrs P where required with personal care. However, as her confidence increased over time, Mrs P was able to carry out more of these tasks herself. Of course, the introduction of the drug therapy may also have played some part in her increased ability to take care of herself in a more independent fashion.

The final activity of daily living that is relevant to Mrs P is sleeping. Mrs P states that one of the first symptoms that were notable was a disturbance in her sleeping pattern. According to Hauser and Zesiewicz (2000), 75-98% of Parkinson's disease patients are affected by sleeping problems. Whilst in hospital, Mrs P suffered with extreme insomnia causing her to become very agitated and upset during the night. She was unable to pinpoint the reasons for this but it could be a combination of several issues. This takes us back to the issue of mobility as she may be unable to make herself comfortable whilst in bed. Another potential problem relating to sleep is the possible side effects of the drug therapy that Mrs P has been taking for the Parkinson's. A known side effect of madopar is in fact insomnia (NHS Choices, 2012), therefore this could be having a detrimental effect on her sleeping patterns. Throughout the latter stages of Mrs P's time in hospital, the preparation for discharge has been somewhat challenging for the nursing staff. Mrs P had numerous discharge dates but each one was postponed due to various setbacks.

With the amount of multidisciplinary input involved, it becomes apparent why this situation is common with a large number of elderly patients. As discussed previously, a home visit from an occupational therapist (OT) is needed to ensure that Mrs P is going to be safe once she returns home. Occupational therapists assess and recommend equipment, such as mobility aids, wheelchairs and artificial limbs and, if needed, advise on special devices to help around the home (BAOT/COT, 2012). Upon the initial home assessment, Mrs P, at first declined to have a stair lift fitted. This delayed

proceedings as the stairs had started to become increasingly difficult for Mrs P to manage subsequently resulting in numerous potential falls from happening. The assessing OT felt that until Mrs P consented to the aids that were being suggested, she was going to be unable to be discharged. However, after a discussion with her daughter, Mrs P did agree to have the necessary equipment put in place. Of course there are numerous other healthcare teams that play a part in the discharge and aftercare of Mrs P. In this particular case, social services were a key element in getting Mrs P home.

It was decided by all teams that a package of care was required to assist Mrs P with tasks at home that she would not be able to fulfil independently, such as; aspects of personal care, housework and shopping. As Mrs P was unable to fund this herself, social services have to apply for the funding. It took a substantial amount of time for the funding to be available thus resulting in a further delay for discharge. Some of the other teams involved in Mrs P's care whilst in hospital included speech and language therapy that was used to assess her ability to swallow; Physiotherapy, to provide proactive advice to improve fitness and manage balance problems and a dietician who can give advice on nutrition and weight management. It is also important to mention the teams that will support Mrs P after discharge. A specialist Parkinson's disease nurse is there to offer advice and support to Mrs P and her family serving as a point of contact for not only them but also the primary healthcare team should new problems arise (Aragon et al, 2008).

All of the members of the multidisciplinary team play an important role in the successful management of Mrs P's Parkinson's disease and help to ensure a smooth transition from hospital back to her home environment. In conclusion, the care and management of patients who are suffering with a long term condition is one that nurses need to approach with a holistic view. It is important to acknowledge not just the patient's physical symptoms but also the psychological, sociocultural and environmental factors that affect each patient individually and in turn can have an impact on how the patient is able to cope with their chronic illness. As discussed, there were various factors that influenced the care that Mrs P received during her stay in hospital. The primary nursing intervention involved was perhaps the administration of the drug therapy that had such a positive effect on Mrs P and enabled her to make some progression towards being well enough to be discharged.

This along with the care that she received from all parties in the multidisciplinary team have provided the on-going support to ensure that she is able to manage her Parkinson's as productively as possible. National Service Frameworks and NICE guidelines have been put in place to assist nurses and other healthcare professionals on how to care for patients with chronic illnesses in a manner that is productive to the patient and their families or carers. Nurses need to put emphasis on the patient as a whole rather than just concentrating on the central problem which in this case is the long term condition. Independence, safety and of course autonomy were all key issues in the case of Mrs P and are usually the prime objectives for

most patients. It is part of the nurse's role to ensure that all of these objectives are met whilst maintaining the dignity and respect of the patient.

REFERENCES

Age UK. 2012. Preventing Falls in Later Life. [Online] Available at:

<http://www.ageuk.org.uk/get-involved/campaign/falls/?ito=2256&itc=0&gclid=CleahpaSmbECFVQ8fAodEgkklw>. (Accessed 6 July 2012)

Allen, N. E., C. G. Colleen., J. C. T. Close., V. S. C. Fung., K. Howard., M. D. Latt ., S. R. Lord., S. M. Murray., S. D. O'Rourke and C. Sherrington. 2009. Exercise therapy for prevention of falls in people with Parkinson's disease: A protocol for a randomised controlled trial and economic evaluation. Bio-med Central. 9 (4) [Online] Available at: <http://www.ncbi.nlm.nih.gov.ezproxy.brighton.ac.uk/pmc/articles/PMC2637228/?tool=pmcentrez> (Accessed: 5 July 2012)

Aragon, A., G. Moore,. D. Robertson and L. Whelan. 2008. Rehabilitation and The Interdisciplinary Team. In: Parkinson's Disease In The Older Patient. Edited by Hindle, J and J. Playfer. 2nd Ed. Oxon: Radcliffe Publishing Limited.

Bishop, M., D. Brunt and E. Protas. 2008. Gait Characteristics and Intervention Strategies in Patients With Parkinson's Disease. In: Neurorehabilitation in Parkinson's Disease. Edited by Lai, E. C., E. J. Protas and M. Trail. New Jersey, USA: Slack Incorporated.

British Association of Occupational Therapists and College of Occupational Therapists. 2012. How OT Can Help. [Online] Available at: <http://www.cot.co.uk/about-ot/how-ot-can-help>. (Accessed 1 August 2012)

Dawson, T. M., V. L. Dawson, D. J. Moore and A. B West. 2005. Molecular Pathophysiology of Parkinson's Disease. Annual Reviews. 28. 57-87. [Online] Available at: <http://www.annualreviews.org/doi/abs/10.1146/annurev.neuro.28.061604.135718> (Accessed: 5 July 2012)

Department of Health (DoH). 2004. Chronic Disease Management. London: Department of Health Publications.

Department of health (DoH). 2005. The National Service Framework For Long Term Conditions. [Online] Available at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_5062950 (Accessed: 5 July 2012)

Gibbs, W. R. G and A. J. Lees. 1988. The Relevance of The Lewy Body to the Pathogenesis of Idiopathic Parkinson's Disease. Journal of Neurology, Neurosurgery and Psychiatry. 51: 745-752.

Hauser, R. A and T. A. Zesiewicz. 2000. The Drug Treatment of Parkinson's Disease in Elderly People. In: Parkinson's Disease and Parkinsonism in the Elderly. Edited by Koller. W. C and J. Meara. Cambridge: University Press.

Horak, F. B and L. A. King. 2009. Delaying Mobility Disability in People With Parkinson Disease Using a Sensorimotor Agility Exercise Program. *Journal of The American Physical Therapy Association*. 89 (4): 384-393.

Hou, J. G and E. C. Lai. 2008. Overview of Parkinson's Disease: Clinical Features, Diagnosis, And Management. In: *Neurorehabilitation In Parkinson's Disease*. Edited by Lai, E. C., E. J. Protas and M. Trail. New Jersey, USA: Slack Incorporated.

Lang, A. E., L. M. Shulman and W. J. Weiner. 2001. *Parkinson's Disease. A Complete Guide For Patients and Families*. Baltimore: The John Hopkins University Press. 5.

Lang, A. E., L. M. Shulman and W. J. Weiner. 2001. *Parkinson's Disease. A Complete Guide For Patients and Families*. Baltimore: The John Hopkins University Press. 47.

Lang, A. E., L. M. Shulman and W. J. Weiner. 2001. *Parkinson's Disease. A Complete Guide For Patients and Families*. Baltimore: The John Hopkins University Press. 51.

Lloyd, M. 2003. The New Community Care for People With Parkinson's Disease and Their Carers. In: *Parkinson's Disease Studies in Psychological and Social Care*. Edited by Hobson, P and R. Percival. Oxfordshire: The British Psychological Society.

Logan, W. W., N. Roper and A. J. Tierney. 1998. The Elements of Nursing. A Model for Nursing Based on A Model of Living. 4th Ed. Edinburgh: Churchill Livingstone. 20.

Logan, W. W., N. Roper and A. J. Tierney. 1998. The Elements of Nursing. A Model for Nursing Based on A Model of Living. 4th Ed. Edinburgh: Churchill Livingstone. 103.

Logan, W. W., N. Roper and A. J. Tierney. 1998. The Elements of Nursing. A Model for Nursing Based on A Model of Living. 4th Ed. Edinburgh: Churchill Livingstone. 283.

NHS Choices. 2012. Madopar Side effects. [Online] Available at: <http://www.nhs.uk/medicine-guides/pages/MedicineSideEffects.aspx?condition=Parkinson%60s%20disease&medicine=Madopar&preparation=Madopar%2050mg/12.5mg%20capsules>. (Accessed: 14 July 2012)

NICE. 2004. Falls: The assessment and prevention of falls in older people. [Online] Available at: <http://publications.nice.org.uk/falls-cg21/key-priorities-for-implementation>. (Accessed 6 July 2012)

NICE. 2006. Parkinson's disease: Diagnosis and management in primary and secondary care. [Online] Available at: <http://publications.nice.org.uk/parkinsons-disease-cg35>. (Accessed 6 July 2012)

Parkinson UK. 2012. What is Parkinson's? [Online] Available at: http://www.parkinsons.org.uk/about_parkinsons/what_is_parkinsons.aspx (Accessed: 5 July 2012)

<https://assignbuster.com/patient-suffering-with-a-long-term-health-problem-essay-sample/>

Roberts, H and P. Overstall. 2008. Motor Problems in Parkinson's Disease: Fluctuations, Gait, Balance and Falls. In: Parkinson's Disease In The Older Patient. Edited by Hindle, J and J. Playfer. 2nd Ed. Oxen: Radcliffe Publishing Limited.

Swinn, L. 2005. Parkinson's Disease. Theory and Practice for Nurses. London: Whurr Publishers. 2-3.