

# Impact of the chronic illness in patients' lives



## **Client Focused Study**

This assignment will focus on the patient's journey and the impact of the chronic illness in their lives. Firstly a rationale for the chosen client and the health deviation will be explained. Secondly, how the deviation has an impact on the patient's journey throughout the health care will be highlighted and potential influences of on long term well being of the patient and their family will be explored. Finally, the knowledge gained from the assignment and how it can be helpful in the future practice will be addressed.

In accordance with the NMC Code of Professional conduct (2010), the patient chosen for this essay will be named Miss X, to protect her identity and maintain confidentiality. Informed consent will be attached as appendix I.

Miss X is a 58 year old patient who had been diagnosed 3 years ago with COPD related to Emphysema. She had been smoking for 40 years and gave up smoking 3 months after her initial diagnosis. She has currently been admitted care to specialised Respiratory ward in a local London hospital, following an exacerbation of COPD. Her current symptoms are chest pain and shortness of breath.

The rationale for choosing Miss X for this assignment is because during my placement in the respiratory ward, I found the patient having difficulties to perform physical activities due to the breathlessness. As a result, I developed an interest in learning how breathlessness occurs and its affect on the patient's daily life. Further rationale of The Nice guidelines for COPD (2010) reported that COPD is the 5th biggest killer in the U. K. and also <https://assignbuster.com/impact-of-the-chronic-illness-in-patients-lives/>

Worldwide. In addition, evidence reports that the main cause of developing COPD is due to smoking. The national statistics General Lifestyle Survey (2008) reported that at least 21% of the U. K's population smoke which means COPD will remain to be endemic in this Country. The annual cost of COPD to the NHS is estimated at more than £980 million and the figures are rising every year. Beraden (2011) reported that incidence of breathlessness in patients' with diagnosed COPD is approximately 65% and 90%. These statistics highlights that it is important to be aware of the health deviation of COPD such as breathlessness in order to ensure the patient receives a quality of life.

Evidently, the pathophysiology of breathlessness caused by emphysema is noted to be a physical development of airflow obstruction and impaired gas exchange. Blackler (2007) explains emphysema as a progressive chronic lung disease where the airways are inflamed and the tissue of the lungs and the alveoli are destroyed. The inflammation in the airway obstructs the flow of air in to the alveoli. In addition, the alveoli lose their elasticity and during breathing this loss can lead to the alveoli collapsing and causing breathlessness.

The main factor causing these characteristics of Emphysema is Smoking. Mc Cance, (2010) informs that smoking cigarette activates the neutrophils which subsequently release the enzymes protease and anti protease. As a result of the toxins from cigarette smoking, the chemical activity of the protease and anti protease is imbalanced. The author further explains that a balance is required in order to maintain normal lung function and the derangements of this balance may result in increased destruction and inappropriate repair of

<https://assignbuster.com/impact-of-the-chronic-illness-in-patients-lives/>

the lungs. Inappropriate repair of the lungs can lead to the alveoli being eliminated of the pulmonary capillary bed, causing mismatching in ventilation and perfusion. As a result there is less surface area for the gases to exchange causing decrease of the oxygen levels in the blood (Mc Cance, 2010). Thus any mild form of exercise can raise oxygen requirement leaving the patient breathless. This is evident in Miss X whenever she performs any type of physical activity.

In addition, Damjanov (2006) explains that the destruction in the alveoli and the bronchiole wall also contribute in the reduction of elastic recoil of the airway. This leads to difficulty in expiration as the loss of elastic recoil reduces the volume of air that can be expired . As the air is not effectively exhaled, air trapping occurs causing the chest to expand. Long term air trapping in the lungs causes the chest to have a barrel like appearance. This is because the lungs are over inflated with air and the ribcage mostly remains expanded which gives the chest its barrel shape (Damjanov, 2006). Barrel chest is very noticeable in Miss X.

People who smoke do not necessarily develop Emphysema therefore inherited genetics disorders are believed to contribute to the development of this disease. McCance, (2010) explains that emphysema mainly occurs with patients who have Alpha 1- antitrypsin deficiency (A1AD). In A1AD enzymes such as elastase destroys the elastin and the tissue of the airway which again leads to mismatching of perfusion of gas exchange and ventilation.

Furthermore, Pryor and Prasad (2009) describes the sensation of breathlessness originates when the sensory system activates within the

lungs, chest wall and the respiratory muscles raise awareness of breathing discomfort. However, psychological factors can also be associated with breathlessness. It is regarded as a subjective experience in COPD anxiety act as an trigger when the patient sense discomfort in breathing. Some studies show the following sequence of events; aggravation by anxiety and panic attacks leads to breathlessness and so forth a continuous cycle is created (Robert and Stockley, 2007)

The patient's journey starts when the patient says so or from diagnosis to the end of life. Three years ago before her diagnosis, Miss X went to see her GP when she started noticing breathlessness whilst performing physical activities. The GP diagnosed Miss X based on her clinical features and other tests; Chest Ct Scan, her Blood test and her spirometry reading which was  $FEV1/FVC < 0.7$ . Initially she was prescribed with Salbutamol MDI 100 mcg 2 puffs PRN to manage her mild COPD. Ever since then she has been taking this medication to help her manage with her daily routines and activities.

The GP also referred her to Smoking Cessation Clinic along with a prescription of nicotine patches which helped her quit smoking after 5 months of her first screening date. The NICE COPD Guidelines (2010) highlights that Smoking Cessation should be recommended to newly diagnosed patients. As stated by the Department Of Health the government targets to reduce the smoking population further than its current 26%, which was achieved successfully by 2010 (DOH, 2010). Despite the government's efforts, literature reviews shows that not all of the patients' fully recover from smoking addiction. The study conducted by Zhou et al (2009) found that out of 2431 patients who managed to quit smoking after Smoking  
<https://assignbuster.com/impact-of-the-chronic-illness-in-patients-lives/>

cessation, 80% were reported to relapse after 3 to 18 months. The data may not be reliable enough to completely prove this high number of relapse because not all the subjects observed carried on for the whole duration of the study. Despite the slight drawbacks of the studies, it has helped the government back up for the funding of smoking cessation clinics.

Along with the Smoking cessation clinic miss X was also referred to have annual Influenza vaccination, Pneumococcal vaccination and was encouraged to regular exercise. Miss X is also seen by the community Respiratory Nurse specialist and community nurse on a regular basis for medical checkups.

Miss X has had few hospital admissions since her diagnosis due to her exacerbation of COPD. On her recent admission she was brought in by an ambulance as she was not able to breathe due to her breathlessness and chest pain. She was immediately admitted to A&E where they diagnosed her with exacerbation of COPD. Miss X was assessed and was stabilised by oxygen therapy and nebulisers in A&E. She was then transferred to the Respiratory ward for further investigation and treatment.

The ward respiratory doctor requested her for chest X-ray, ECG, Arterial Blood Gases test, blood test, urine dipstick test and sputum culture. The investigation confirmed that she had chest infection. Her oxygen saturation was also maintained by oxygen therapy. Miss X was then started on nebulisers, I. V. antibiotics and for a 7 day course she was on oral prednisolone (Steroids). Jong et al (2007) suggest that oral prednisolone is

recommended than I. V prednisolone because there was no difference on treatment and helps reduce patient to be prone to infection.

During the stay in the ward Miss X was noticed to be underweight and was referred to the dietician who prescribed her to nutritional drinks and given advice on healthy eating. She was also seen by the Physiotherapist for breathing techniques and mobilising with the breathlessness. As Miss X has had few admissions due to her exacerbation she was also referred to pulmonary rehabilitation after her discharge. The NICE (2010) highlighted that pulmonary rehabilitation improves the patient's quality of life and therefore, any COPD patient of grade 3 on the MRC scale (Medical Research Council) should be referred to the programme after being discharged. Currently the government suggests that the standard population for rehabilitation up take of the programme should be 230 patients per 100, 000 of a normal population in a trust per year. This is a very small number of uptakes in relation to the COPD population; such limitation can create restrictions to access the rehabilitation programme.

The deviation can have an impact on the long term well being of Miss X and her Family. COPD is a disease that progress over a long time along with severity of its symptoms. ( 20) confirms that COPD over time results in fatigue, depression, anxiety, reduced exercise tolerance and poor nourishment.

Firstly, the effort to maintain normal ventilation, all the energy of the patient is consumed causing tiredness and fatigue restricting the patient's ability to perform everyday activities. Miss X interprets her breathlessness has

restricted her to perform physical activities and therefore retired from her waitress job at the age of 56. This has led to her being financially dependent on her 22 year old son and government disability financial support. She also relies on her son to help her with household chores as she is not able to perform certain activities by herself such as shopping, cleaning, washing, cooking, paying bills etc.

Furthermore, Lahaije et al (2010) proved that COPD patients do eliminate their daily activities due to physiological limitation caused by breathlessness. The study was conducted on 21 COPD patients and ten healthy subjects living in Netherlands. The study measured the performance time for daily living activities; where COPD patients were involved less whereas healthy subjects were higher. The study consisted of only 21 COPD patients and 10 healthy subjects which is a very small sample therefore cannot be generalised. However, the study conducted by Szarm (2010) on a survey of 20693 patients residing in England who were aged between 51- 60 year old were reported to also have an impaired work performance due to breathlessness mostly caused by COPD. The finding from Szram (2010) is more reputable than Lahaije et al (2010) with regards to generalising COPD patients limiting breathlessness as the sample size was much larger

Miss x also suffered from urinary incontinence. Literature reveals that patients with COPD do suffer from stress incontinence of urine due to increased abdominal pressure whilst coughing (Tozun et al, 2009). However, some authors forget that inability to reach the toilet in time due to breathlessness could be the factor influencing urinary incontinence in COPD patients.



Secondly, the disability caused by Miss X's breathlessness has also had an impact on her psychological state. Numerous studies have proved that the symptoms of COPD can cause patients to be depressed and affect the quality of life. Stage et al (2009) literature review highlights that depression is common in COPD patients and about 40% of the COPD diagnosed suffer from either severe or clinical depression. The literature review also noted that mortality rate was lower in non depressed COPD patient than the depressed.

In addition, she feels that she is a burden to her son and feels embarrassed on having sudden panic attacks in public whilst she is out shopping or socialising. Miss X reported that she felt devalued as she experienced being treated differently by others and also feel socially isolated. The qualitative study conducted by Berger et al (2010) confirms that COPD patients do experience stigmatisations which are triggered by self blame related to smoking, being a burden, embarrassment. Stuenkel and Wong (2009) highlight the Goffman's theory of support groups in which the patients shares similar stigma. The support group evidently has helped to feel accepted, gain moral support. The Breathe Easy support group programme Miss X attends every fortnight has helped her to reduce her stigmatisation.

In light of all this, Miss X does have a positive attitude to cope with her condition. She is aware that her condition is not curable but can be managed if she complies with the treatment. She is adherent to her medication and her treatment plan. Naidoo and Wills (2010) explain that the Health locus of control (HCOL) is divided into two controls; internal where people are in control of their condition and external where people are beyond control of

their condition. Miss X falls under the internal HCOL as she controls her condition very well.

Lastly, Miss X's son is very worried about his mother going to have an emergency admission to the hospital again. The patient's son is psychologically stressed and feels socially isolated due to financial and household commitments. However, he has been accessing support and advice from the doctors, nurses and special support groups. Moreover, the review of qualitative studies conducted by Spence et al (2008) explored the specific care needed of care givers of patients with COPD. The review confirmed that restricted activities of daily living and emotional distress were identified by the 7 subjects studied.

This assignment has helped me to understand the impact COPD has on the patient, family and health care system. The skills and knowledge gained to care for the COPD patient will ensure an evidence based care will be delivered to the patient and the family. In future, whilst nursing a patient with breathlessness I will follow the guidelines as directed by the NICE guidelines as care required. I will also consider the psychological and social state of the patient on planning the care as these are the main aspects of the disease which impact the patient's quality of life. To overcome any issues if countered, social issues will be referred to the social services and any psychological issues should be referred to the clinical psychologist. Finally, I have learned that educating patient and the family of services available and the disease itself is the key to aid them cope and comply with the treatment.

In conclusion, the assignment overviews a journey of a patient diagnosed with emphysema with the health deviation of breathlessness. The NHS has been providing treatment and therapies to reduce the risk of patients developing emphysema. Literature reviews indicate that breathlessness can contribute to several psychosocial issues in the patient's life.

Word Count 2499

## References List

Beraden, K. (2011). Recent advances in the management of breathlessness. Indian Journal Of Palliative Care. 17 (4), 29-32.

Szram et al. (2010). Breathlessness and work performance in older adults in Kent. Thorax. 65 (4), 78-79.

Stuenkel, D and Wong, V. (2009). Stigma. In: Larsen, P and Lubkin, I Chronic illness: impact and intervention . 7th ed. USA: Jones and Bartlett Publishers. 57.

Jong et al . (2007). Oral or IV Prednisolone in the Treatment of COPD Exacerbations\* A Randomized, Controlled, Double-blind Study. American College of Chest Physicians. 132 (1), 1741-1747.

Tozun et al. (2009). Prevalence of Urinary Incontinence among Women and Its Impact on Quality of Life in a Semirural Area of Western Turkey. Gynecologic and Obstetric Investigation . 67 (1), 241-249.

Berger et al. (2010). The Experience of Stigma in Chronic Obstructive Pulmonary Disease. Western Journal of Nursing Research. X, 1-17.

<https://assignbuster.com/impact-of-the-chronic-illness-in-patients-lives/>

Spence et al. (2008). Active carers: living with chronic obstructive pulmonary disease. *International Journal of Palliative Nursing*. 14 (8),

Stage et al. (2006). Depression in COPD- Management and quality of life considerations. *International Journal of COPD*. 1 (3), 315-320.

Department of Health. Consultation on a Strategy for Services for COPD in England. London: Department of Health, 2010.

British Thoracic Society. Burden of Lung Disease 2006.

National Institute for Health and Clinical Excellence. Chronic obstructive pulmonary disease (update). (Clinical guideline 101.) 2010. <http://guidance.nice.org.uk/CG101>. Last Accessed 20/02/2011

Office for National Statistics. (2010). 12. General Lifestyle Survey 2008: Smoking and drinking among adults,. Available: [http://www.statistics.gov.uk/downloads/theme\\_compendia/GLF08/GLFSmoking&DrinkingAmongAdults2008.pdf](http://www.statistics.gov.uk/downloads/theme_compendia/GLF08/GLFSmoking&DrinkingAmongAdults2008.pdf). Last accessed 20th Feb

National Institute for Health and Clinical Excellence. (2006). Pulmonary Rehabilitation service for patients with COPD. Available: <http://www.nice.org.uk/usingguidance/commissioningguides/pulmonaryrehabilitation-service-for-patients-with-copd/pulmonary-rehabilitation-service-copd.jsp>. Last accessed 20th Feb 2011.

McCance et al (2010). Pathophysiology, The Biologic Basis for Disease in Adults and Children. 6th ed. Missouri: ELSEVIER. 1286-1289.

<https://assignbuster.com/impact-of-the-chronic-illness-in-patients-lives/>

Nursing & Midwifery Council (2008) The Code: Standards of conduct, performance and ethics for nurses and midwives NMC, London

Blackler et al (2007). Managing Chronic Obstructive Pulmonary Disease. England: John Wiley and Sons LTD. 1-12.

Damanjov

Pryor, J and Prasad, S (2008). Physiotherapy for respiratory and cardiac problems:. 4th ed. UK: Elsevier. 227- 228.

Mahler, D. (2007). The Physiology of breathlessness. In: Robert, A and Stockley, I Chronic obstructive pulmonary disease. Oxford: Blackwell

Zhou et al . (2009). Attempts to quit smoking and relapse: Factors associated with success or failure from the ATTEMPT cohort study . Addictive Behaviors. 34 (4), 365-373.

Naidoo and Wills