**HCAGE 3061**

**AGE CARE NURSING**

**INDIVIDUAL ESSAY: CASE STUDY**

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Australian population is getting older at a fast rate and people aged 65 and above are increasing quickly than all the other age group (Happell & Stefan, 2011). By the year of 2051, 28% of the people will be over 65 years of age signifying more than 100% increase in the latest figures (Australian Bureau of Statistics [ABS], 2006).

Growing older appears to be closely associated with decline. In ageing there is an accumulation of frail and abnormal tissues, molecules and cells over a lifetime (Heemels, 2010). And old age is the biggest contributor to many diseases including cancer, dementia, cardiovascular disease and neurodegenerative diseases as well as loss of some body and sensory function such as hearing, sight and mobility (Heemels, 2010).

 Older adults have good and bad experiences from advancing age. Ageing can be viewed as personal development for a concrete wisdom, but also undermined by the changes in the ability to decide on their own, low self-esteem and feeling of worthlessness (Naumanen, 2006). Ageing is not identical with disease. Regrettably, growing older goes together with illness and disability. Truth is that , the ageing body can perform most, if not all, of the role of its youth; changes is that they may take longer time, requires greater effort and be less accurate (Porth & Matfin,2009).

Nurses should possess a deeper understanding and skills for the variety of roles and responsibilities needed in providing quality care for older people (Crisp & Taylor,2009). The goal of this essay is to analyse and provide intervention for problems with depression, hearing and vertigo, nutrition and dementia in a holistic approach. And this essay will focus on Olivia’s promotion of autonomy and feeling of self-worth.

 Refer to Appendix A , for Olivia’s case study

Refer to Appendeix B for the services available in the community.

 First of the identified problems of Olivia is depression a mental health problem that is common among older people and is a communal health dilemma that directs to functional disability (Lyness, 2004).Inability to recognise and provide intervention will worsen impairment and other medical issues. Contemplating the experiences that the adult person is undergoing such as retirement, living alone, lower income, loss of body function ,changes in body images and death of love ones are factors that explain why depression is a major problem among elderly (Mynatt,2004).

 Death of a significant person is a major life crisis and because of this grief is experienced holistically, affecting a person emotionally, mentally, physically and spiritually ( Varcarolis & Halter,2010). Most of the elderly encounter death or loss of love ones, including members of the family and friends. The death of a spouse is illustrated as a severe experience that takes a long time to recovery (McGrath, Holewa & McNaught, 2010). Olivia is having a difficult time processing the idea that death has occurred. And Olivia’s forgetfulness can be a manifestation of unacknowledged grief. According to Hughes & Heycox (2010), denial is a conventional response when a person is about to face a massive change in their life for example illness, disability and death. Some person, move away from the information that cannot be process at the moment. And Nurse should further explore Olivia’s statement of not feeling lonely because McKissock (1999), stated that it is not normal for person who lost a love one to act as if nothing happened- this indicates that the person needs professional help( as cited in Dawdin & Rogers,2008).

 It is important for the Nurse to acknowledge that reaction from grief does not always occur in sequence (Varcolis et al., 2010). Some person may not manifest normal reaction to bereavement. For some people, emotions are expressed in private or in a practical way, the person who’s grieving find ways to divert their feeling so that they wont get exhausted in coping with the extreme emotions (Niemeyer,2000., cited in Hughes et al,2010).

 Olivia’s overly active life style shows that the patient is always pre-occupied with activities. Nurse must aid the patient to recognise stressor and assess the degree of stress. And ask client to identify positive coping done in the past that help her through (Tabloski, 2006).

 Olivia is socially active symptoms of withdrawal is not evident in her case because the client is using diversion by keeping busy and active at all times. Focus of this intervention is to explore and let the client verbalize feelings and help in examining behaviours and coping mechanism that is above normal (Tabloski, 2006). And refer the client to community resources available such as support groups, stress-reduction clinics and other stress alleviation group.

 Second of the identified problems that Olivia have is hearing impairment which can rigorously influence person’s ways of living. Hearing loss can hinder with communication, entertainment, safety and autonomy (Tabloski, 2006). Hearing impairment happens in all age groups, but is common in older adults. Given reasons for this includes constant exposure to loud noises, hereditary and some disease. And auditory problem scale starts from slight loss to total deafness.

 According to World Health Organization (2006), there will be an estimated 1.2 billion people aged 60 and above all over the world by 2025. It is said that about 25 % of aged 65-75 years and 70-80 % of aged 75 years suffers from aged-related hearing loss by 2025( Sprinzl & Riechelmann,2009).

 Olivia is suffering from intermittent hearing loss that brings forth irritation while talking over the phone.

There are common hearing deficits in older adults. First is, presbycusis a sensorineural hearing loss related to aging, patient experience a slow and bilateral hearing loss (Liu & Yan,2007). Most of the time the older people think that there is no problem with their hearing but unable to comprehend spoken words and often thinks that the speaker is mumbling. The second common deficit is the Impacted cerumen , in older adults cerumen is more harder and drier so the tendency of the cerumen is to build up along the ear canal. Third is the exposure to loud noises attributed to the kind of work or environmental exposure encountered (Tabloski, 2006).

 The consequences of hearing impairment on older people are vast and this includes limitation in activities due to; speech perception factors include noisy surrounding or inability to read speakers lips, inability to comprehend broadcast signals in the radio and television, inability to hear footsteps ,cars, door bell and telephone ringing (Laplante-Levesque,Hickson & Worrall). The outcome of these limitations extends beyond activities of everyday life but also affects older person’s sense of being and quality of living.

Nurse must assess the patient then refer the client to the Australian Government of Hearing Service Program. This program offers free assessment by a qualified hearing practitioner, free hearing aids and additional services are given to complex hearing problems. http://www.health.gov.au/internet/main/publishing.nsf/Content/health-hear-applic.htm

 Intervention should be focused on promoting communication because hearing deficit can cause isolation due to inability to communicate (Crisp et al, 2009). Nurse must be effective in teaching the client ways and method of conversing to other people like use of sign language, lip reading, writing in a pad and computers (Crisp et al.,2009)

 According to Laplante- Levesque et al (2011), remedy interventions for aged person with hearing impairments are hearing aids, hearing assistance technology and communication programs. Hearing aids intensify sounds suitable for the client. Hearing assistance technology are supportive gadgets that aids access to auditory information examples are cordless headphones, induction loop on public areas, amplifiers for radio and televisions and teletypewriters. Communication programs focuses on enhancement of language perception and communication management.

 Referral to the safe environment is important among older people in order to feel secure without losing their sense of autonomy. Placing amplifiers at home is essential particularly in doorbells and alarm clock. Sound lamps, that activates with sound to light that signals the deaf person to sounds like doorbell, telephones, fire alarm and even babies crying (Crisp et al.,2006.p.1405). Safety is not a major problem now days due to technology as Nurse Olivia must be well inform on how to use the devices that are put inside their houses.

 It is also important that nurses evaluates course of action given to determine if the intervention is effective in terms of improvement or least maintain ability to interact and blend in the environment( Crisp et al,2009).

 Third problem is vertigo is a feeling of light-headedness producing a sensation of rotating motion and unsteadiness. It is said to be that vertigo and dizziness is a usual symptoms in the general population with a prevalence of 5% to 10 % in various age groups (Cesarani, Alpini, Monti & Raponi,2004). In older adults, dizziness becomes a serious dilemma than in any other age bracket due to risk of falls, weakness and reduced cognitive functions (Katsarkas, 2008). Dizziness in aging should not be taken for granted for safety purposes.

 Health teaching on how to reduce frequency of attacks should be provided Nurse must inform the client to stop from smoking, avoid consumption of caffeine and alcohol, change diet into a low salt(Riggs & Anderson,2011). Stress is another factor that triggers the attacks, observe for signs and symptoms of anxiety and depression and offer techniques for relaxation such as the basic breathing technique (Rigg et al, 2011).

 Cognitively empower client by feeding information about the disease and allow the patient to ask questions. Social network must be strengthen by providing information of the available support groups in the community like Meniere’s Australia which has vertigo information and support group.

 Focus of nursing care is to lessen vertigo and promote patient safety in the environment. During an attack patient is place in a comfortable position in a quite darkened room. Instruct the client to avoid abrupt movement or changes in position. And flickering light and television can aggravate the situation. And remember that after the attack the client will need assistance in ambulation ( Brown & Edwards,2008).

 Fourth problem is Olivia’s nutrition. Food provides nourishment to the body. And older people have different nutritional needs. A well balanced diet means is consumption of few calories and increase intake of foods rich in mineral and vitamins (Tabloski,2006).Adequate food intake is important to ensure that enough water is present for bodily functions. Nurses must meet the nutritional needs of older people, through support during meals giving attention to the amount of food and water consumed ( Holm & Soderhamn ,2003). If client is unable to cook nutritious meal there is a community service available, nurse must inform the client about food services such as meals on wheels that cater food for specific diets.

 Fifth problem is fall the major cause of injury for older adults. There are several factors that cause risk of falls like coordination problem, unsafe shoes, poor nutrition, hearing impairment, visual impairment, alcohol use and side effect of medications(TAFE,2007). As a nurse fall prevention must be use

 Last problem identified in Olivia’s case is dementia an advancing syndrome of brain disease distinguish by problems of short term memory and decrease in intellectual function (Holmes,2008). Olivia’s concern of getting dementia, points to the forgetfulness she experiences and the GP is concerned that there is some degree of dementia and further test is needed. Access Economic (2005), approximates that t 1.7% of men and 1.3 % of women from aged 65 to 69 has dementia and for aged 95 and above 38.1% for women and 40.3% for men has dementia. Occurrence of dementia in Australia is estimated multiply of about 370 % from 197,900 in 2004 to 731,030 in 2005 (cited in Hughes et al.,2010).

 There are types of dementia and the common types are Alzheimer’s disease (AD), produce by irregular knot and plaque in the brain, most of the time it is a slow onset. Vascular Dementia (VaD), is caused by a cerebrovascular disease, often follow a stroke or series of minute stroke. Another common type is Dementia with Lewy bodies (DBL), instigated by abnormal development of brain cells and the progress is rapid. Frototemporal Dementia (FTD),is a damage from the frontal, anterior, parietal and temporal lobes that produces changes in behaviour and personality. Last is Mixed Dementia (MD), basically the combination of different types of dementia (Holmes, 2008.). There are also less common types of dementia Parkinson’s disease, Alcohol related dementia, Huntington’s disease, Crutzfield Jacob Disease, Drug related dementia and Head injury dementia (Hughes et al, 2010).

 The fundamental signs of dementia are decline in cognitive and functional ability with behavioural and psychiatric that proves to be stressful and devastating for the client (Kalapatapu & Neugroschi, 2009). Some of the common symptoms observed are repetition of questions and stories, forgetfulness (Olivia’s complain), losing things and getting lost in common surroundings. Another classic signs are changes in point of reference, like inability to remember names of friends, family and home address as well as orientation to time, year and month (Varcarolis et al.,2010). In terms of behavioural changes, there is a decline in hygienic practices and appearance, withdrawn, and inability to make judgement. Emotional changes are seen through inability to handle stress, changing moods and socially withdrawn (TAFE,2007).

 Once presented with symptoms it is essential that early diagnosis should be done to give the patient time to plan their future. In the case of Olivia she tends to be forgetful categorised as a memory loss and the GP said that there is some degree of dementia and that further test must be done. And according to Hughes et al. (2008), the process of diagnosis will engage preliminary test by the medical practitioner, followed by a more thorough evaluation by experts involving team’s geriatrician, psychiatrist, psychologist and neurologist.

 Doctor will refer patient to Aged Care Assessment Team (ACAT), this are teams of health professionals like doctors, nurses or social workers that provides information, counselling and aid to older adults who has problem living alone. And after the assessment is done, discussion on whether a person can be admitted in a residential care and what is the right type of care best suit person with dementia and Olivia is most likely be put in the low care (TAFE, 2007).

 Admission to a residential care for some older adults, are the worst experience ever. It disrupt their normal way of life (Aneshensel , Pearlin, Levy-storm & Schuler,2000).When transferring a patient from home to a facility, Nurse must carefully plan the transition involving family, carers and health care workers. It is important to consider patient feeling of fear and confusion. It will help ease the patient if you bring some things that are memorable to them like picture frames, painting anything that will make them comfortable. Allow them to arrange their things it gives them a sense of worth (Aneshensel et al.,2010).

 People with dementia need assistance in social activities to promote self esteem and maintain the skills they still possess. Nurse should promote activities that will make use of skills that a person still have, provide simple and unhurried activities, avoid actions that will alleviate stress, remember that performing certain skills may differ from a day to day basis, avoid noisy activities and crowded environment, and sensory experience like massage, brushing hair and stroking an animal is pleasant for people with diminished abilities (Varcarolis, 2010).

 Safety is important with people with dementia remove mats, cords and extension on the floor, provide night lamps in the toilet and hallways, automatic cut offs for hot water, place rails in the toilet, bathroom and stairs, smoke detectors must be installed properly and front and backyards must be check as well as gate catches(TAFE,2007).

 Nurse must also inform Olivia about the Advance Care Plan (ADP), wherein patient have the right to decide on medical treatments and consent regarding their care. And patient is given a chance to plan ahead of time. There are four ways to record Advance Care Plan (1) Appointing medical power of Attorney(2) Completing an Anticipatory Direction, if the client have wishes in treatments and even decide on care of the 3 cats whether the family or the animal foundation will take charge(3)Appointing Enduring Power of Guardianship, in the event that the client cannot decide for themselves the appointed one will take over(4) documenting patient’s wishes in the statement of choices.

 In conclusion, with the projected increase in the number of older adults in the coming decades, it is important to elevate the awareness on the dilemmas of older adults such as in area of care, management and services available in the community. And management should be focus not only the disease itself but also on maintaining a quality life that encompasses person’s emotional, physical, mental, social, environmental and spiritual aspects of living.

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INTERNET RESOUCES

<http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-dementia-recognising.htm>

Date Accessed: 5/5/2011

 <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-hear-applic.htm>

Date Accessed: 5/5/2011

**APPENDIX A**

Olivia is a 75 years of age and lives in an outer Melbourne suburb. She owns her own house and lives alone following the death of her husband 12 months ago. She has three cats that are well fed and pampered. Olivia has been attending gym each day, has a personal trainer and regularly walks for 20km three times a week. She says that she never feels lonely and always finds someone to talk to when she is out walking and swimming at the local heated pool.-Her family is settled in other areas of the state and they visit each other monthly, and ring weekly. If they are in Melbourne for other things they usually call in and see her. Olivia has had increasing vertigo and intermittent hearing loss that she describes as annoying when she is ‘on the phone’. She had recently had a bout of gastroenteritis which made her quite dehydrated and she required a short stay in hospital. Olivia keeps mentally active by reading, completing crosswords, brain games and using the internet. She is concerned that she is getting dementia as she forgets things easily. The GP is concerned that there is a degree of dementia and wants to send Olivia for more tests. This is frightening for her as she has always been mentally active and managed a large business until her retirement at 70. Olivia believes that she has excellent health and does not take any medication.

**APPENDIX B**

COMMUNITY SERVICES AVAILABLE:

 Commonwealth Carer Resource Centres

 Commonwealth Care link Centres

 Aged Care and Community Care Information Line (1800500853)

 Commonwealth Carer Respite Centre (1800059059)

 Alzheimer’s Australia (1800 100 500)

 National Dementia Helpline ( 1800 100 500)

 The National Carer Counselling (1800 242 636)

 Home and Community Care (HACC) ( 1800 052 222)

 Home Help and Home Modification under HACC (1800 052 222)

 Home Nursing Services (1800 052 222)

 Food Services “Meals on Wheels” (1800 242 636)

COMMUNITY CARE PACKAGES (1800 500 853)

 This are packages designed to help people stay at home by coordinating the different services they need.

 Community Aged Care Packages

 Extended Aged Care at Home packages (EACH)

 Linkages/ community option