



NURSING CASE STUDIES ON

**IMPROVING
HEALTH-RELATED
QUALITY OF LIFE IN
OLDER ADULTS**

**MEREDITH WALLACE KAZER
KATHY MURPHY**

EDITORS

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Springer Publishing Company, LLC
11 West 42nd Street
New York, NY 10036
www.springerpub.com

Acquisitions Editor: Elizabeth Nieginski
Production Editor: Kris Parrish
Composition: S4Carlisle Publishing Services

ISBN: 978-0-8261-2703-7
e-book ISBN: 978-0-8261-2704-4

15 16 17 18 / 5 4 3 2 1

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Library of Congress Cataloging-in-Publication Data

Nursing case studies on improving health-related quality of life in older adults / [edited by] Meredith Wallace Kazer, Kathy Murphy.

p. : cm.

Includes bibliographical references and index.

ISBN 978-0-8261-2703-7—ISBN 978-0-8261-2704-4 (e-book)

I. Kazer, Meredith Wallace, editor. II. Murphy, Kathy, 1953- , editor.

[DNLM: 1. Geriatric Nursing—methods. 2. Case Reports. 3. Quality of Life. WY 152]

RC954

618.97'0231—dc23

2014047655

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Printed in the United States of America by Gasch Printing.

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PREFACE

This book fulfills a substantial need among the gerontological nursing literature. While quality of life (QOL) is often discussed in relation to the care of older adults, there is a substantial gap between patient and family wishes and clinical practice implementation. This gap can be filled only through knowledge and communication. Through the development of this book we aim to advance education for nurses in clinical practice in an attempt to resolve gaps in the care of older adults. Gerontological nursing care has made substantial advances over the past several decades; however, we continue to support efforts toward further improvement. We are hopeful that this book will lead gerontological nurses toward a higher level of care. Nurses caring for older adults are poised and ready for this advancement. The strength of this book is the ability to link real patient cases with the evidence and provide practical strategies for improving this care.

In this book, we have chosen to highlight a number of commonly occurring issues among older adults. The first section examines global issues that are important to QOL. As in the entire book, each chapter opens with a case study, reviews the literature, and provides specific strategies for improving QOL for individuals and families. The cases showcase the experiences of older people as they struggle to maintain autonomy, dignity, and a sense of self amid the aging process and declining health. The chapters provide a lens through which to examine challenges of aging and strategies that may be implemented to promote QOL. The middle section of the book is organized around 15 chapters that direct the lens toward a number of environmental issues that impact the QOL of older adults. The cases contained in this section explore the experiences of older adults at home and in assisted living and nursing home environments. Evidence-based literature reviews enhance the discussion of care issues that impact older adults and their families. The authors of these chapters use clinical experience and the evidence to improve understanding of issues that impact the QOL of older adults across these multiple care environments. The final section of this book is organized around 12 chapters that may function as a clinical resource guide for clinicians. Cases are presented to improve clinical reasoning and improve understanding of issues that older adults encounter in preventing and managing acute and chronic disease states.

Some of the chapters focus on commonly occurring medical issues; others explore less common health care conditions.

As we prepared this book, we selected contributors who are on the front lines of health care for the aged and have been involved in both clinical practice and research. In this way, the cases are realistic and moving. In addition, the literature selected is up to date and comprehensive. We understand that these cases are not the beginning and end of all knowledge on the topic areas presented, but we are confident that they will inspire the necessary dialogue. As readers journey through these cases and the supporting literature, it is our hope that they will increase their understanding of issues that impact older adults across environments of care and stimulate effective assessment and management strategies.

We are hopeful that this book stimulates discussion, knowledge development, and improved care for the rapidly increasing population of older adults worldwide. However, we understand that it is only a small contribution. We are indebted to our contributors for sharing in our desire to increase the care of older adults and to Springer Publishing Company for investing in this care. However, we also look forward to a future when the care proposed within this volume becomes standard and an improved QOL for older adults is realized. It is only with such contributions that this goal may be attained.

*Meredith Wallace Kazer
Kathy Murphy*



ACKNOWLEDGMENT

The authors wish to gratefully acknowledge the contributions of Reverend Michael Fahey, S.J., Scholar in Residence at Fairfield University, who devoted his time and attention to the thoughtful and comprehensive editing of this book. We remain forever in his debt.

I

FOUNDATIONS OF QUALITY IN OLDER ADULT CARE

KATHY MURPHY

Maintaining quality of life (QOL) into older age is one of the important challenges facing the growing aging population and governments across the world. While QOL is a useful and widely used expression, its apparent simplicity masks the complexity and ambiguity surrounding the actual meaning of the concept. QOL is difficult to define and to measure as it is made up of interacting objective and subjective dimensions, which may change over time in response to life and health events and experiences (Bowling, 2003). What is really important, therefore, is to ensure that health care is focused on the components of QOL that matter to older people and have in place strategies for maximizing QOL into older age.

The opening section of the book is devoted to an exploration of the issues that are important to QOL of older people. In most of the chapters of this section, QOL is divided into specific domains. Each chapter contains a case study, supporting literature, and specific strategies for improving QOL within that domain. The cases reveal the experiences of older adults in a variety of environments as they struggle to maintain their quality, autonomy, or dignity within the context of aging and deteriorating health. The chapters provide insights into some of the challenges that occur in QOL issues across living environments and strategies that can be used by nurses to promote quality of life.

Each chapter presents a case study and supporting literature; the case study gives both the objective and the subjective appraisal of the issues described. Consideration of the material in the chapters will enable nurses to increase their understanding of issues that extend across environments

of care and strategies they can use to maximize good assessment and management. The cases in this section describe some of the QOL concepts that underpin the foundations of care for older people. Using the case study framework, nurses can develop enhanced clinical knowledge regarding how the ethos of care can impact on the QOL of older adults and how some of these issues can be addressed.

This section of the book is organized around eight chapters that focus attention on a number of environmental and theoretical issues that impact the QOL of older adults. The first chapter explores the case of an older woman who lives alone following the death of her husband. Now, while physically well, she is finding life a struggle, is feeling low, and finds it increasingly difficult to do the work of maintaining her home. Through the review of literature, Drs. Murphy and Kazer explore the overall concept of QOL and strategies to enhance QOL. In the second chapter, Dr. Coyle explores the impact of person-centered care on the QOL of older adults living in nursing home environments. She describes the concept of person-centered care and identifies solutions and strategies to enable care to become more person centered.

In Chapter 3 of this section, Dr. Welford and Ms. Sweeney consider the issues impacting on the autonomy of an older man recently admitted to nursing home care. Relevant exploration of the literature into the concept of autonomy is provided in this chapter. Care planning strategies and the use of a core daily life plan are explored in this chapter. The ability to make choices in the way you live your life in nursing home environments is explored in the next chapter of this book. In Chapter 5, Dr. Murphy challenges caregivers to find ways to promote independence amid institutional climates that often engender dependency. In Chapter 6, Dr. Jacelon explores the challenge of maintaining dignity across care environments and describes how this concept is increasingly important as people age.

Chapter 7 explores the complex issues of risk, what this means, and the tools that can be used to help nurses make risk assessments balanced alongside consequences. The need for risk avoidance to be balanced with older adults' needs, values, and overall QOL is identified. In the last chapter in this section, Dr. Kazer explores the complex issues of sexuality and aging through a case study of an older woman who is experiencing some difficulties with intercourse.

The many case studies and evidence-based literature reviews contained within this section expand the discussion of meaningful QOL substantially. The authors of these chapters use clinical experience and sources

to enhance understanding of issues that impact the QOL of older adults. The solutions and strategies contained herein are, in many cases, easily implementable and can significantly impact the QOL of older adults and their families. Each chapter presents a unique QOL issue and uses the case study approach to broaden understanding of nurses and, consequently, to promote QOL for older adults.

Reference

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1

QUALITY OF LIFE

KATHY MURPHY AND MEREDITH WALLACE KAZER

Subjective

"I am just so alone now."

Objective

Mrs. Abigail Ames is a 72-year-old woman who lives alone in a small town on the west coast of Ireland. Her husband died last year. He had a massive myocardial infarction while gardening and died instantly. Mrs. Ames has three grown-up children who are all living abroad. Mrs. Ames visited her family practitioner last week because she was feeling down. She said she has found life on her own quite lonely—her husband had been her main companion. She has one sister who is living in Northern Ireland and, while they get on well, they rarely see each other because both are widowed and neither can drive. After the death of her husband, there was a lot to do, and the children had been over a few times in the first year, but, she says, "They have their lives to get on with now." The children bought her a new dog, her beloved dog Toto, as they were concerned about her being in the house alone, and she said she still feels nervous about nights on her own. Mrs. Ames has a good work pension; she was a university administrator, owns her own house, and says she has no financial concerns. Her house is a bungalow, well equipped and cared for. She is a very organized person who has a personal computer and laptop and what she describes as reasonable IT skills. She is finding the garden a burden, especially as she cannot get the lawnmower to start, so recently she has stopped cutting the grass and has the young boy across the road do it for her. Mrs. Ames used

to enjoy golf and reading, but lately her eyesight has deteriorated, and she is finding reading difficult, especially at night. Mrs. Ames is a Catholic, but has found herself less interested lately in the organized church. Mrs. Ames says that her life is lonely and difficult, and she finds it hard to pass the day. She misses her children and her husband, and has lost interest in going out.

On examination, Mrs. Ames is 156 cm (61 in.) in height and weighs 190 lbs. (86 kg). Her blood pressure (BP) is 170/90; her pulse (P) is 120 respirations, 22 per minute; she is overweight with a BMI of 29; her waist circumference is 88 cm (35 in.). She says she has put on a bit of weight since giving up her daily walk that she used to do with her husband, and has recently stopped cutting the grass also. Overall, her physical health has been good; she has recently been prescribed BP medication, but otherwise describes herself as physically well. Recently, she has been feeling low in mood, which she attributes to her husband's death. Her current medications are Lisinopril 20 mg po daily. She is not a member of any local groups at present.

Literature Review

Populations across the world are aging; the World Health Organization (2012) predicts that the proportion of the population over 60 will double, rising from 11% in 2000 to 22% by 2050. The number of people over 80—the older old age group—is predicted to rise even more markedly, quadrupling between 2000 and 2050 and reaching 395 million. Currently, it is estimated that, in the United States, 10,000 individuals a day are turning 65 years old; this trend is expected to continue for over the next two decades, and by 2030, 20% of the population, or 72.1 million people, will be older adults (Administration on Aging, 2010). In this context, it is important to think about the quality of life of older people and the strategies that nurses can use to enable older people to live well.

Quality of life (QOL) has gained increased attention as a significant factor in the care and management of many nursing problems over the past several decades. In the past, physical problems generally led to more rapid mortality and

subsequently less suffering. Little attention was paid to the impact that those physical problems had on other aspects of life. Today, previously incurable diseases are now treated and sometimes eradicated, leading to the prolongation of human life. The end result is a population of older adults previously nonexistent in recent history. The challenge this newly evolved population presents is in designing health care systems that seek not only to prolong the quantity of life, but also to improve the QOL. In fact, Senator Charles McMathias Jr. in 1979 showed early insight into the challenges of the growing older population when he stated:

I simply cannot believe that we, who accomplished the miracle of prolonging life, are willing now to watch that miracle turn into a Frankenstein monster. We cannot let longer lives mean only more suffering and greater loneliness. We must make those extra years shine for our elderly. I believe we will. (McMathias, 1979, p. 386)

George and Bearon (1980) tell us that QOL had its origins in the concept of "the good life" as described by the philosopher Aristotle; both concepts are fundamentally about the QOL. Aristotle proposed that "the good life" was a life that was worthwhile, fulfilling, virtuous, and lived in a way that enabled the capacity for rational action to be realized (Smith, 2000). Traditional Chinese philosophy also made reference to QOL, suggesting that a good QOL was achievable if there was harmony between yin and yang (Zhan, 1992). John Seth, a Scottish philosopher writing in the 19th century (Seth, 1889, p. 43), proposed that longevity and QOL should be seen as equally important and viewed enhancing QOL as a moral end toward which mankind should aspire (Smith, 2000).

The term QOL did not appear in the *International Encyclopedia of Social Sciences* until 1968. Bond and Corner (2004) suggest that research interest in QOL was ignited around this time within the context of expanding economies and increasing affluence. It was not until the late 1970s, however, that entries regarding QOL began to appear in health care literature, and research into the impact of care on QOL has expanded

exponentially in the past three decades (Bowling, Banister, Sutton, Evans, & Windsor, 2002; Bowling et al., 2003; Fry, 2000; Gurland & Katz, 1991). QOL has become an important outcome measure for many care interventions, so it is important to understand what it is.

QOL is difficult to define and measure precisely. QOL is comprised of both objective and subjective elements, which may change over time and are impacted by life, deteriorating health, and overall experiences (Bowling, 2003; Murphy, O'Shea, & Cooney 2007a). Some researchers have attempted to understand QOL by examining what life is, what quality is, and how they intersect. *Taber's Cyclopedic Medical Dictionary* (2005) defines *life* as the "state of being alive; quality manifested by metabolism, growth, reproduction, and adaptation to environment; state in which the organs of an animal or plant are capable of performing all or any of their functions." Webster defines life as "the quality that distinguishes a vital and functional being from a dead body; a principle or force that is considered to underlie the distinctive quality of animate beings." Interestingly, the word *quality* is seen in both definitions of life. This reveals that the two words that form the concept are closely related and well understood by both health care professionals and lay people. In addition, the listing of the manifestation of the qualities of metabolism, growth, reproduction, and adaptation empowers the construct of multidimensionality.

Human needs may also provide part of the foundation for QOL, and this can be an important influence on the theory and practice of measurement (Bowling & Gabriel, 2004; Browne, O'Boyle, McGee, McDonald, & Joyce, 1997). Maslow's (1970) *A Theory of Human Motivation and Personality* outlines a needs-based approach to measuring QOL that adopts a hierarchical stance. At the bottom of the hierarchy are the basic needs, which are the physiological needs, followed by the safety and security needs. These needs are deemed to be essential for human survival, and it is not until they have been fully satisfied that an individual will seek to fulfill higher level needs. When the physiological and safety needs have been gratified, then love and affection and belongingness needs will emerge. These include the need for affectionate relationships; for example, with family and friends. When this need is satisfied, the

individual will strive to fulfill the esteem needs that include a feeling of self-respect and self-confidence and the gaining of the respect of others. Finally, Maslow maintains that even if all of the aforementioned desires are met, an individual will not be at peace until he or she has fulfilled the need for self-actualization, that is, that "the individual is doing what he/she, individually, is fitted for" (Maslow, 1970). In other words, the individual must be able to realize and express his or her full potential, whatever the circumstances, what Sen (1993) might describe as maximizing capabilities.

In an attempt to isolate the concerns relevant to individual QOL values, researchers have attempted to define QOL by evaluating the needs and values of individuals within different population groups or environments of care. There has therefore been a focus on QOL of older people (Bond & Corner, 2004; Bowling et al., 2003; Grewal et al., 2006), QOL of older people living in long-stay care (Ball et al., 2000; Berglund & Ericsson, 2003; Cooney, Murphy, & O'Shea, 2009; Hubbard, Downs, & Tester, 2003; Kane et al., 2003; Leung, Wu, Lue, & Tang, 2004; Murphy et al., 2007a; Tester, Hubbard, Downs, MacDonald, & Murphy, 2004), and QOL and disability (Bowling, 2007; Bowling et al., 2003; Farquhar, 1995; Grewal et al., 2006), resulting in a wide spectrum of opinion and perspectives. QOL also has relevancy across disciplines and has been explored within economics, sociology, psychology, philosophy, medicine, nursing, social history, and geography (Bowling & Brazier, 1995; Farquhar, 1995). Bringing together all these diverse perspectives is important in order to really understand what QOL is. However, because disciplines examine QOL through different disciplinary lenses and older people experiencing different circumstances and living environments may emphasize different components of QOL, this exploration has given rise to a variety of interpretations (Anderson & Burckhardt, 1999).

Measurement of QOL has therefore been problematic. Initially, QOL scales designed to capture QOL focused on objective indicators such as finances and assets. However, it quickly became evident that these elements were not sufficient for fully understanding QOL. Therefore, researchers started to include subjective measures within QOL scales such as

well-being, happiness, and life satisfaction (Farquhar, 1995; Murphy, O'Shea, Cooney, & Casey 2007b; Smith, 2000). These subjective measures are important to ensure that QOL studies focus on what is important to people, but their inclusion gives rise to a more complex and individualized definition of QOL that in turn makes comparison complex and stakeholder consensus difficult to achieve. QOL, however, is now regularly used as an outcome measure in evaluation of health care interventions and in economic analysis (Bond & Corner, 2004; Smith, 2000). Issues of cost-effectiveness and Medicare revisions inspired exploration into the substantial expenditures to keep people alive for years on respirators and other life-sustaining equipment, only to have such people die or return to a life considered undesirable.

Gurland and Katz (1991) conducted an extensive review of QOL literature in the context of older people. Through a process of content analysis, they developed a list of 19 domains in which QOL should be evaluated. These domains include: mobility, four areas of activities of daily living, organizational skills, orientational skills, receptive communication, expressive communication, health and perceived health, mood and symptoms, social and interpersonal relations, autonomy, financial management, environmental fit, gratification, future image, general well-being, and effective coordination. The validity of this model has not yet been tested in the area of QOL assessment.

It is also clear that although full consensus in relation to the determining components of QOL of older people remains elusive, there are some important domains of QOL that are emerging across research studies. These are health; psychological well-being, including spirituality, social relationships, activities, home, and neighborhood; and financial circumstances (Bond & Corner, 2004; Bowling et al., 2003; Farquhar, 1995; Grewal et al., 2006).

Researchers often identify physical health as an important influence on QOL. However, there are some important differences in the value placed on physical health; people who are generally healthy are more likely to stress the importance of good health, whereas people with significant disabilities often emphasize the importance of abilities rather than physical health (Murphy et al., 2007b). Psychological well-being is also

frequently identified as an important factor for good QOL because it can shape how you perceive your experiences and life in general. Spirituality has been identified as important, with many older people identifying this as central to their QOL.

According to Bond and Corner (2004), family and kinship, good social relationships (Bowling et al., 2003), and close bonds with others (Borglin et al. 2005) are critical to QOL. The quality of relationships has been found to be an influencing factor in the engagement that people have with their communities, families, and friends. Various studies have also found a positive correlation between engagement in meaningful activities and QOL for older people (Farquhar, 1995; Grewal et al., 2006), and involvement in social activities, local community, and voluntary organizations also contributes to a good QOL (Bowling et al., 2003).

Home and neighborhood have also been identified as important to QOL (Bowling et al., 2003) as the physical environment can help or hinder independence, provide material comforts, or hinder or facilitate outdoor activities. Material circumstances and income have been identified as important to QOL (Bowling et al., 2003; Murphy et al., 2007b). Income allows older people more opportunities to participate in economic, social, and cultural life.

Role and Cultural Considerations

Providers caring for Mrs. Ames must consider the multiple QOL dimensions within a cultural context in order to improve health outcomes for this client. From a physical perspective, she is accustomed to visiting her provider and has a strong relationship, illustrated by her ability to share her concerns. Little is known about her spiritual practices. However, she has been a practicing Catholic until recently. Thus, conducting a spiritual assessment and referral to clergy may be within the role of the provider. From the economic perspective, Mrs. Ames seems comfortable enough and may consider traveling in the future. The loss of her role as a wife appears to be among her biggest challenges. Referral to support services for grief counseling may be appropriate within the early months following

her husband's death. Then reconnecting with social avenues, through social clubs, senior services, the church, and volunteer activities, may be instrumental in helping Mrs. Ames to connect with others. Her social life was strong prior to her husband's death, and this projects strong possibilities for the future. From a cultural perspective, she may be less inclined to ask for help. Thus, a consistent assessment regarding QOL issues at each appointment will help to keep these multiple dimensions of the concept a top priority from the provider perspective.

Strategies to Enhance QOL

Relationships and connection to others have been described as determining of QOL. Mrs. Ames said she was feeling low in mood, was lonely, and missed her children and husband. Therefore, considering strategies to reconnect Mrs. Ames to her sister, family, and friends is important to overall QOL. Mrs. Ames was a university administrator, and because she has good computer skills, Skype could be one technology that could help her connect to her family. Group Skype could give her the capacity to talk to her children together; raising this with her may help facilitate her connectedness. Her family also needs to understand that she is lonely, and discussing the importance of telling them with Mrs. Ames may help her to ask the family for more support. Connections to the local community are also important, particularly as so many people withdraw rather than engage as they get older. Mrs. Ames used to walk daily. There is a walking group that meets twice a week in the town where she lives, and joining this group may help Mrs. Ames to reduce weight and increase her overall fitness and connect her to some of the community activities. There is also a local book club, and although Mrs. Ames is finding reading more difficult because of her eyesight, an e-reader with adjustable fonts may help her with her reading issues and give her the confidence to join the group.

Purposeful activity is also a key QOL issue, and doing activities that are meaningful and fulfilling matters. Mrs. Ames has many skills that could be of great value to the local community; the local active retirement group has been struggling to find someone to do their accounts, and Mrs. Ames may be

able to use her skills to benefit the group. Community nurses have a wealth of knowledge about what is happening at a local level and may be able to identify opportunities for engagement. Getting Mrs. Ames involved and engaged in community activities may impact positively on her mood and psychological well-being.

Mrs. Ames stopped cutting the grass when she found it difficult to start the lawnmower. Many older people reduce the level of physical activity they do as they age; however, this may impact negatively on their overall levels of fitness and physical health. Therefore, identifying ways of continuing to undertake physical activity is important. It may be that spreading the activity over a longer time and getting help to undertake the activity is a better strategy than stopping engagement in the activity altogether. Mrs. Ames could get the young boy to start the lawnmower for her or she could replace the lawnmower with one that starts more easily. This may all help to keep Mrs. Ames active and fit for longer.

There are many domains that are relevant to the QOL of older people, and as populations age across the world, it is important to ask how the care given by nurses impacts on the QOL of the older people they care for and what strategies can be used to improve QOL. To date, there are few books that provide evidence-based analysis of QOL among older adults and across environments of care, and none that focus on strategies that can improve QOL. This book identifies how nurses can contribute to improving the QOL of the older people for whom they care.

Clinical Reasoning Questions

1. Considering the multiple dimensions of QOL, what interventions would you recommend for Mrs. Ames?
2. To whom would you refer her and in what priority? How can shared decision-making systems be developed?
3. Mrs. Ames's health status is stable. However, what if she were ill and homebound? How would this change the plan of care?

4. Have you ever worked with clients such as Mrs. Ames before? If so, what strategies did you find most effective in improving their QOL?

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