

Running Head: FAMILY AND CHRONIC ILLNESS

Family and Chronic Illness: A Home Visit

This home visit provided a unique opportunity to observe the effects of chronic illnesses on clients and their families outside of the clinic setting. As we have learned throughout this semester, it is not possible to separate the impact of chronic illnesses on the client's and family's health and vice versa. This paper will address this complex interaction of clients, families, and chronic illness. It will begin with a description of the client with whom I visited and his family. I will then discuss the family theory that I used to guide my assessment of and resulting plan of care for this client. Next, I will apply Rolland's typology of chronic illness to this client, including the illness type, time phase of the illness, and the components of family functioning. Next will be an analysis of the client, his family, and their overall circumstances, followed by identification of nursing and medical diagnoses, a plan of care, and expected outcomes specific to this client and his family. Finally, I will provide an overall reflection and critique of the entire experience and the resulting plan of care. A family approach will be used throughout the paper.

I had the pleasure of making a home visit to a client from the Detroit VA Medical Center, with whom I had previously established a relationship. I had seen Mr. P, as I will refer to him, on two separate occasions and followed up with him via telephone several different times; in addition, he was my subject for the client education project earlier in the semester. Mr. P is a 68-year-old Caucasian male who is being followed at the VA for the care of several chronic diseases, as well as for primary care. I have attached SOAP notes for the two occasions that I saw Mr. P in the clinic for further information regarding his health history (see Appendices II and III). A brief list of his chronic illnesses is as follows: Diabetes Mellitus type II (DM), diabetic neuropathy, nicotine dependence, osteoarthritis (OA) / chronic pain, and hyperlipidemia.

Since I had gotten a lot of 'medical' information about Mr. P's chronic illnesses during clinic visits, I wanted to focus on how he felt his illnesses had affected his life in addition to

exploring further some of the family issues that we had briefly discussed during those visits. Mr. P was very open and amenable to having me come for this home visit, and we began by going over the family genogram (see Appendix I for genogram). This yielded quite a bit of information, and it was something that I continually added to and referred to throughout the visit.

Mr. P was married twice. He has two daughters from a previous marriage from “when I was very young” (in his early 20s) and none with his second wife. His first marriage lasted only a brief time and “ended badly.” He does not speak with or have any sort of relationship with his first wife, who lives in Tennessee. After their divorce, Mr. P had custody of his youngest daughter, while his first wife took custody of their oldest daughter. He has a strained and tumultuous relationship with this eldest daughter, 45, and did not have much contact with her while she was growing up. She now lives in Florida. Mr. P stated that “she’s just like her mom, and we don’t get along; I haven’t spoken to her in years, and the only time she ever calls is when she needs money to bail her boyfriend out of jail.” This daughter has three children of her own, which Mr. P does not know well; he was unsure of their ages. However, he does have a close relationship with his youngest daughter (age 43). She lives in Tennessee with her husband and two sons, one of whom is married. Mr. P states that “I haven’t seen her since she came up for her step-mother’s funeral in 2003, but we talk at least every week on the phone.” Mr. P thought that both his daughters kept in contact with their mother, but he was not sure.

Mr. P married his second wife not long after the divorce from his first wife. He stated that “my youngest daughter was only about three or four when we got married, so she thought of her as her mother.” He recently lost this wife of 40 years when she died of a stroke in 2003. She died in the hospital, where she had gone after experiencing a fall. Mr. P described his wife as “pretty healthy” but stated that her health had begun to decline somewhat before this

hospitalization; he told me that this was not the first time she had fallen at home. “She was getting pretty unsteady.” However, Mr. P expressed anger when he discussed his wife’s death – “I don’t think she should have died there; I think they gave her too much morphine and that made her have a stroke, but I never had them do an autopsy.” He claimed to have known other people who had received “bad care” at this particular hospital and had “also died.” Mr. P seemed to feel very negative about how his wife had died, but it was difficult to determine the exact circumstances surrounding this event. He did not seem to want to go into great detail at this time, and I did not feel that it would have been beneficial to further explore this at this first visit. Mr. P stated that he got along very well with his second wife; “We got by just fine together.” He said he had been lonely and missed her since her death but described himself as “a loner anyway, and I’ve gotten along okay” since that time.

One major area of focus was Mr. P’s social/emotional life after retirement. He described himself as “active” and stated that he has often been “bored and a little lonely” since his retirement and wife’s death. Mr. P retired at age 60. He had worked as a security guard most of his life, which he stated he enjoyed “as long as I could walk around a lot.” He also talked about his time in the Marines, which was before his first marriage while he was in his late teens and early twenties. Mr. P served two and a half years as a Marine (“I never served in a war”) and remembered his time in California with fondness. He told me that “It was hard work, especially during boot camp, but I really enjoyed the whole experience. I would have stayed in if they hadn’t discharged me for failing a hearing exam.”

These days, Mr. P stated that he tries to keep himself busy by working around the house and participating in several hobbies, including walking outside and in the mall, using his metal detector, fishing, and drawing. However, he states that “I still feel bored and depressed

sometimes.” Mr. P does have a good relationship with his sister who lives nearby and with whom he visits “almost every day, in the morning.” He also gets on well with several other family members, such as his brother in California, his brothers-in-law, his son-in-law, and his nieces (his sister’s daughters). In addition, he stated that he maintains a friendly relationship with several of his neighbors; he cuts lawns for two of them.

Another aspect of Mr. P’s social assessment had to do with his house. Mr. P’s house was small but very neat and well-kept, both outside and inside. The lawn was trimmed, and he had a lovely garden in the front, which he said he enjoyed tending. Mr. P is currently in the process of trying to sell his house so that he can move to Florida, where he is hoping to be by the end of the year. Although he spent much of his younger years in Detroit, he said that he grew up in Tennessee and has a love for the south. He stated that he vacationed there with his wife several times and showed me a picture of the two of them together there during a past vacation. He said that he was looking forward to moving to a warmer climate, which he thought “might help some of my aches and pains.” To sell his house, Mr. P was “trying to get it in shape” by re-painting the three bedrooms and re-decorating the bathroom. He expressed pride in his work as he showed me the two rooms he had already painted.

Finally, we discussed the impact of Mr. P’s chronic diseases on his social and emotional life – diabetes and hyperlipidemia, osteoarthritis/chronic pain, and nicotine dependence. I praised Mr. P for the reduction in levels of both his hemoglobin A1c and cholesterol levels in recent months. When I asked him about his diabetes, he said that he had been diagnosed “about twenty years ago” and that this particular illness “doesn’t bother me much.” He told me that although he usually eats what he wants, his diet is still fairly healthy overall. “I don’t deny myself food if I want it, but I don’t really care about eating all that much and try to eat well.”

However, Mr. P did state that he found having to check his blood sugar and take the pills was “annoying – if I ever want to go somewhere, I always have to think about bringing everything and remembering to check.” He told me that “I just don’t like having to take a lot of pills in general.” He was not sure how this diagnosis had affected his family, but he did tell me (with a tinge of pride) that he was the only one he knew of in his entire blood-related family with DM.

Another ‘chronic’ diagnosis that Mr. P and I had spent time working on since his first visit was his addiction to tobacco. He smoked one pack per day for many years, since he was in his teens, and had cut back to a half pack per day in the last six months. During his first visit, he stated that he was ready to try quitting. We prescribed the nicotine patch for Mr. P, and he successfully cut down to one cigarette per day. (I had previously educated him that, if he absolutely had to smoke, it was very important to take off the patch before smoking. He told me that he always did this, stating that “I usually only smoked one in the evening before going to bed, and the patch was always off beforehand.”) However, during the visit, Mr. P told me that quitting had been very difficult and admitted that “I’m up to about two or three cigarettes a day now.” Despite knowing the health risks, he said that cigarettes were a long-established part of his daily life for many years, and that giving up smoking at certain times of the day was the most difficult. Although Mr. P had declined to take the smoking cessation class several times, he said that the patch had helped “a lot” and that he still had the desire to continue quitting.

Finally, Mr. P stated that, of all his chronic illness, his chronic pain was the most intrusive and bothersome to him. Mr. P suffers from OA (mainly in his back) and bilateral lower extremity diabetic neuropathy. He states that these illnesses have a significant impact on his level of activity, which then “makes me feel cooped up and depressed.” For the pain, he takes Vicodin and was recently prescribed Elavil, both of which provide some relief. He experienced

some relief from the neuropathy after taking the Elavil, although he found the side effect of a dry mouth to be very annoying. Regarding the Vicodin, we had encouraged Mr. P to begin taking more than his usual two tablets a day to see if this would provide more consistent relief for him throughout the day. He had expressed reluctance to this idea at his last visit due to fears of addiction. Although we reassured Mr. P that this was a very unlikely possibility, he told me during the home visit that he had still not begun taking more. He described how the pain often kept him from being able to work around the house, and I noticed that Mr. P had to stand up and walk around after sitting in the chair for about 15 minutes, due to stiffness and soreness.

A caveat to this pain assessment was a brief observational assessment I made of Mr. P's mobility and mental status. When we walked outside at one point, I noticed that Mr. P walked stiffly and seemed unsteady at times, which concerned me for his risk of falls. Also, though he remained alert and oriented throughout the entire visit (as well as during the other visits), he did seem to have some trouble remembering dates and ages while I was completing the genogram.

Finally, there were a few other areas that I assessed during this home visit: neighborhood safety, access to shopping, finances, spirituality, and depression. When giving me directions to his house in Westland, Michigan (outside of Detroit), Mr. P said he lived in a part of town that was "sort of like 'The Projects'." When I drove to his house, I passed by an elementary school with children playing in the playground; the surrounding areas struck me as low income but were very well-kept, as were the houses on Mr. P's street. He told me that the neighborhood got "a lot worse" in the areas beyond his house, and he encouraged me *not* to travel that way on my way home. He told me that he did feel safe, however, walking around in his neighborhood as long as he did not go to the "bad" parts. He stated that he often walked up to the park/playground to use his metal detector there. Overall, I felt very safe on his street and walking up to his house.

Regarding shopping and finances in general, Mr. P stated that there were plenty of shops within a short distance where he shopped for food and other items. However, when I asked him about finances, he described them as “pretty tight” and said that he lived on about \$700 of income per month. He told me that he was very concerned when he had to drive now, due to the high gas prices, and was worried that he would not have enough money to move to Florida. However, he was not worried about selling his house and felt that he would not have much trouble with this – “I’ve already had a couple prospective buyers.”

Next was my assessment of spirituality in Mr. P’s life. I noticed a crucifix hanging on his kitchen wall and asked him about the importance of religion and spirituality in his life. He replied that, although he did not attend church, this was certainly a part of his life and that he considered himself to be a “spiritual person, not necessarily a religious one.” He stated, “I have strong spiritual beliefs but don’t feel I need or want to go to church.”

Finally, I assessed Mr. P’s level of depression. Overall, Mr. P struck me as a pleasant, cheerful, and basically happy person, but I was concerned about his previous mentions of occasionally feeling lonely and depressed. Mr. P was amenable to this assessment, and I asked him the 15 questions of the Geriatric Depression Scale (see Appendix IV for this scale and Mr. P’s scores). His score placed him in the ‘mild depression’ scale. I shared this with Mr. P and told him that I would let my preceptor know about this so that we could address it at his next visit. He stated that he would be open to the idea of exploring treatment options for this.

The following are the nine areas that Mr. P answered which placed him in the ‘mild depression’ category. First was “Are you basically satisfied with your life?” Mr. P said he was not due to the state of his overall health and resulting decreased energy. Second was, “Have you dropped many of your activities and interests?” Mr. P replied that he had given up some of his

favorite activities due to his chronic pain, such as fishing. Next were, “Do you feel happy most of the time?” and “Do you prefer to stay at home rather than going out and doing new things?” Mr. P stated that he tried to be cheerful but often felt depressed. He also told me that, because he thought of himself as a loner, he mostly preferred to stay home. The fifth and sixth questions assessed feelings of boredom and life emptiness; Mr. P replied ‘yes’ to both. Next, he stated that he did not feel in good spirits most of the time but that he “tried to be.” Finally, he felt that he had some problems with memory and forgetfulness and also that he had decreased energy.

The next main section of this paper will summarize a few of the components of the family approach I chose to use while working with Mr. P. The theory I used with which to guide my assessment was the Calgary Family Assessment and Intervention Model (Wright & Leahey, 2000, ch. 3 & 4). During this home visit, I was working with only one member of a family, and I felt that this model would be more straightforward than Rolland’s model, which looks at a family’s adaptation to chronic illness (Rolland, 1994). Since none of the other family members were present during this visit, I found the Calgary Model to be more relevant.

The Calgary Model is divided into two broad categories of family assessment and family intervention, each of which is then broken down into further categories and subcategories. As the authors suggest, to maintain efficiency and prevent the nurse from becoming overwhelmed during the visit, I did not cover every component during my assessment (Wright & Leahey, 2000, p 67-68). There are three components to the family assessment portion: structural, developmental, and functional assessment. The structural category has three subcategories (internal, external, and context), each of which is then each broken down to further subcategories. The developmental category also has three subcategories (stages, tasks, and

attachments) but no further divisions. Finally, the functional category contains two subcategories: instrumental and expressive (both of which contain further subcategories.) (p. 68). For each of the three main categories (structural, developmental, and functional), I will discuss their particular subcategories relevant to this particular visit. The second part of the model is the intervention portion, which I will discuss under the analysis of the client/family situation, after discussing Rolland's typology of chronic illness.

Within the structural-internal category, I chose to look at two subcategories: 'family composition' and 'boundaries'. Authors Wright and Leahey (2000) describe a currently accepted definition of the concept of family as a unit whose members may or may not be related or live together, may or may not contain children, includes the presence of a commitment for future obligation among members, and has functions that include protection, nourishment, and socialization (p. 69). This broad view of family was helpful, as Mr. P certainly did not fit into the typical 'nuclear' family. He was essentially a family of one, with an extended family that did not live with him.

Under this definition, Mr. P's family might include his youngest daughter and her family, his sister and her family, his brother and brothers-in-law, and his neighbors, as these were all people with whom Mr. P expressed commitment, attachment, protection, nourishment, and socialization. Mr. P spoke highly of his nieces, lit up when talking about his youngest daughter, and expressed happiness when talking about his interactions with the other aforementioned groups. Wright and Leahey (2000) encourage nurses to broaden their view of family and suggest that "attributes of affection, strong emotional ties, a sense of belonging, and durability of membership" define family better than simple blood relations (p. 70). As evidenced by our conversation, Mr. P may consider his neighbors 'family' more than his ex-wife or oldest

daughter. This ties into the next category – boundaries, or, “defining who participates and how” (p. 76). The authors describe boundaries as having the ability to facilitate or constrain functioning (p. 76-77). Based on what Mr. P told me about his relationship with his oldest daughter and how she only called when she needed money, I assessed that he found these boundaries somewhat constraining. In addition, he told me that he would not move to Tennessee, even to be closer to his youngest daughter and family, as “my ex would be coming around every day to bug me and ask me for something – I just want to do my own thing without a lot of relatives bothering me.” This may fall under the constraining category as well.

The next major category under the structural portion of the model is external structure. The one subcategory from this section that I used is larger systems, or the “larger social agencies and personnel with whom the family have meaningful contact” (Wright & Leahey, 2000, p. 79). In this case, due to Mr. P’s military background, the VA (as well as the government in general) is a social system with which he is intimately involved. Mr. P does have insurance and has visited other health care providers in the past but currently receives all his health care through the VA, due to high co-pays with his insurance. Wright and Leahey (2000) state that it is important to assess the impact of these systems on the client and family (p. 79-80). Mr. P told me that he was fairly happy with the care he received at the VA, mainly due to satisfaction with his provider (my preceptor). He was also thrilled with the home visit in general; “This is the first time I’ve ever had a provider visit me in my home.” One example of a larger agency having a negative impact on health is that Mr. P was badly in need of dental care, as he only had a top plate of dentures and no lower plate. However, dental care at the VA was not covered for him as it was not considered to be ‘service connected.’ Also, Mr. P’s relationship with the larger agency of the

government is an important part of his life; he is retired and depends financially upon his monthly government stipend from his service to the military.

The third and final structural category is 'context', under which I chose to assess 'social class,' 'environment' and 'religion and spirituality'. First, Mr. P would probably be placed in a 'mid' to 'lower' social class category, based on income and housing. Wright and Leahey (2000) state that this category in general "affects how family members define themselves and are defined" (p. 83). Also, based on Mr. P's description of himself and his sister living near a 'bad' neighborhood, as well as his monthly income, his environment surely affects both himself and his family. Finally, spirituality was obviously an important part of Mr. P's life. The authors encourage nurses to be aware of this in clients and families, especially as spirituality often becomes an important coping source when dealing with a chronic illness (p. 85).

The second broad category of the assessment model is developmental assessment, which includes the subcategories of stages, tasks, and attachments. Mr. P would be in the Family Life Cycle Stage 'Families in later life,' which starts at retirement and ends with the death of both spouses (Wright & Leahey, 2000, p. 114). Tasks for this stage include maintaining functioning and interest in the face of physiological decline and dealing with the loss of spouse or others (p. 114-115). With the recent loss of his wife along with Mr. P's chronic pain and subsequent loss of activity, these will be challenging tasks for Mr. P to face, and the strength of his attachments to his remaining family will be important to assess. For instance, I asked Mr. P if he felt there was anyone he could go to if he needed help, whether financial, physical, or emotional; he stated that his sister was very supportive and was a good resource in this area. In addition, if and when he moves to Florida, he will be closer to his youngest daughter, who may be able to help care for

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him as he continues to age. For these reasons, it would be appropriate to have further family visits that included both his sister and his daughter, if possible.

There are two other areas of this Life Cycle which I would like to discuss. The first considers divorce and subsequent remarrying (Wright & Leahey, 2000, pp. 116-124). Although this occurred many years ago for Mr. P, it still has a permanent impact on family functioning. The simple fact that Mr. P's two daughters were separated from each other (and each from a parent) would have had a huge impact on their family relationships for the rest of their lives. As I said before, it would be important at some time to try to include other family members in an ongoing family assessment. Also, the authors include a comparison of life cycle stages for professional vs. low-income families. These two sets of families face very different sets of life challenges. Whereas a professional couple in their 40s may be concerned with such tasks as putting a child through college, a low-income couple of the same age is more likely to be dealing with their children having children of their own (Wright & Leahey, 2000, p. 126). This reminded me of Mr. P's relationship to his eldest daughter, who has had several children out of wedlock with whom he does not have relationships.

The third and final category of the Calgary Model is functional assessment, which includes both 'instrumental' and 'expressive' assessments. The instrumental assessment includes the area of activities of daily living (ADLs). Wright and Leahey (2000) stress the importance of assessing this area, particularly as it relates to dealing with chronic illnesses (p. 129). This is a relevant issue concerning the ubiquitous impacts that Mr. P's chronic illnesses have had on his life. For example, Mr. P's chronic pain and resulting stiffness and decreased activity would certainly have an impact on his ADLs.

Under the ‘expressive’ category of functional assessment, I included ‘emotional’ and ‘verbal communication’, ‘problem solving,’ and ‘alliances and coalitions.’ During the visit, the concept of communication stood out to me as a part of his life worthy of assessment. He has two extremes of verbal communication with his two daughters – positive verbal communication with his youngest and virtually no communication with his eldest. The occasional verbal communication between Mr. P and his oldest daughter serves only to upset and further distance him from her. Wright and Leahey (2000) describe emotional communication as “the range and types of emotions or feelings that are expressed, shown, or both” (p. 131). Mr. P expressed quite a bit of emotional communication regarding the loss of his wife and the anger that he felt, as well as disappointment and irritation directed toward his ex-wife and oldest daughter. He did not seem to express much regret over these dysfunctional relationships, and I feel that it would be therapeutic to further explore these thoughts and feelings with him.

This leads into the next category of problem-solving, which is also relevant for Mr. P. Wright and Leahey (2000) describe this as “the family’s ability to solve its own problems effectively” (p. 139). It is obvious that this ability is seriously lacking when it comes to Mr. P’s eldest daughter and ex-wife. As Mr. P faces the final stages of his life, he may desire to renew a relationship with at least his daughter, and problem-solving would be an essential tool for both Mr. P and his family. And finally, this is directly related to the third subcategory, which is ‘alliances and coalitions’. Mr. P’s alliance with his youngest daughter was strongly established early on when he retained custody of her and his other daughter moved in with her mother. The strength of these alliances may become more pronounced and affect any possible attempts to reestablish relationships if Mr. P ends up moving to Florida.

The next main portion of this paper will discuss and apply Rolland's typology of chronic illness to Mr. P. For this section, I chose to focus on two of Mr. P's chronic illness, as I felt they were representative: DM type 2 (including hyperlipidemia, diabetic neuropathy) and OA (including overall chronic pain). In Rolland's model, there are five distinctions of chronic diseases presented: onset, course, outcome, incapacitation, and predictability (1994, ch.2). In addition, there are five illness characteristics that Rolland refers to: symptom visibility, likelihood/severity of crises, genetic contributions, treatment regimens, and typical age at onset (1994, ch. 2).

The onset of an illness is subdivided into 'acute' and 'gradual'. Acute onsets of illnesses require more rapid adjustment, problem-solving skills, and involve a more abrupt strain on the family, whereas a chronic onset allows a slower adjustment period (Rolland, 1994, p. 23-24). According to Rolland, both DM and OA have a gradual onset (p. 35). Mr. P was not sure of the impact these diagnoses had on his family, but their gradual nature may have allowed more time for things to settle and allowed a smoother transition to aspects such as checking blood sugars, taking more medications, and decreased levels of activity related to OA. It would have been particularly interesting to see what the impact of Mr. P's diabetes was on his wife, as she was the one who spent the most time with him after his diagnosis. This may also have affected his youngest daughter, although she would have been in her mid-20s when he was diagnosed.

Next is 'course', which can be progressive, constant, or relapsing/episodic (Rolland, 1994, p. 24). Again, both the DM and OA fall into the same category according to Rolland: 'progressive,' which is described as "continually or generally symptomatic," "increases in severity," and does not allow a family to 'settle in' to a certain level of functioning (p. 24-25). While this is true to a certain extent with these diagnoses, I would broaden this classification

somewhat. For instance, DM could be considered ‘relapsing/episodic’ with regard to frequent blood sugar checks, the taking of antidiabetic medications or insulin, and the possibility of hypo- or hyperglycemia. In the same vein, OA could be considered ‘constant’ if it is well-controlled. But whatever the classification of ‘course,’ this would have an impact on both Mr. P and his family. For instance, if he moves down to Florida, his daughter may end up caring for him as he ages and his chronic illnesses worsen. This would require a further family assessment that included the members of his family that would be caring for him.

Next is ‘outcome’, which is classified as ‘fatal’, ‘non-fatal’, and ‘possibly fatal/shortened life-span’ (Rolland, 1994, p. 29). Again, according to Rolland’s model, both Mr. P’s DM and OA are considered nonfatal (p. 35). This is good news for Mr. P, as neither illness is classified as one that would particularly shorten his life. However, I would argue that DM may be placed in the category of ‘shortened life-span’ related to its many complications (neuropathic, cardiovascular, etc.).

The fourth classification is ‘predictability’, and here again, Rolland’s classifications match DM and OA as predictable, which allow the client and family more time for planning and involves less ambiguity as to the course of the illness (2004, pp. 33-36). But once again, I would at least consider placing DM as ‘unpredictable’ in regards to the possibility of hypo- or hypoglycemic episodes.

The final category is ‘incapacitation’, and here the two illnesses differ: DM is considered non-incapacitating, while OA can be incapacitating with its effects on activity (Rolland, 1994, pp. 31-32). While Mr. P’s diabetes is certainly annoying and bothersome, his OA has had a more debilitating impact, based on the resulting pain and decreased level of activity. Rolland measures incapacitation as anything from physical impairment to social stigma (p. 31). In this

way again, both diseases could be considered incapacitating to some degree, as Mr. P expressed some displeasure and embarrassment at having to take his glucometer on trips.

Next are the five illness characteristics, which I will describe in relation to Mr. P. ‘Symptom visibility’ refers to anything ranging from external symptoms (i.e., disfigurement, rash) to more subjective or invisible symptoms, such as high blood pressure or pain (Rolland, 1994, pp. 36-37). Mr. P’s DM is mostly outwardly invisible, except for potential times of hypo- or hyperglycemia or taking glucometer measurements. Regarding OA, pain would be a subjective finding, whereas Mr. P’s decreased level of activity would be more visible. Next is ‘likelihood/severity’ of crises, which might include the possibility of hypo- or hyperglycemia or any OA flare-ups. ‘Genetic contribution’ is next, with both DM and OA having a potential genetic pathogenic component (Goodman & Uphold, 2003, pp. 164-165; Uphold, 2003, p. 836). Mr. P did not know of anyone else in his family with either of these illnesses, but he was not entirely sure of family health history either. Fourth is ‘treatment regimens,’ which refers to the time and energy spent dealing with these diseases on a day-to-day basis (Rolland, 1994, p. 39). I would place the DM in a more complicated regimen category, as it involves checking of blood sugars, while his OA may be somewhat simpler to manage with pain medication and activity. The final consideration is ‘age at onset’, which is typically in the middle-age to older adult population for both DM and OA (Goodman & Uphold, 2003, p. 164-165; Uphold, 2003, p. 836).

The final sections of Rolland’s typology refer to the time phase of the illnesses, which includes the crisis phase (the period when the patient is symptomatic before diagnosis, and initial readjustment and treatment after diagnosis), the chronic phase (the period between initial diagnosis and the terminal phase in which the family experiences the ‘long-haul’), and the terminal phase (where death is inevitable, and the family copes) (Rolland, 1994, pp. 43-51).

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Each phase has its own issues and key family tasks that must be successfully completed for the patient and family to cope with the demands of that particular phase; if these transitional tasks are not met, the family will become ‘stuck’ in that particular phase where the goals were not met (pp. 48-49). Mr. P would be in the chronic phase for both his DM and OA. This phase, unlike the other two, requires *less* cohesion among family members; issues include avoiding burnout and preserving individual and family goals (pp. 48-49). Key family tasks include trying to maintain as ‘normal’ a life as possible and giving family members room for individuality and autonomy in the face of the chronic illnesses (p. 48-49). Since Mr. P lives alone, and has lived with these chronic illnesses for many years, assessing the status of these issues and tasks by his family would be difficult to determine. These may become more important if Mr. P moves to Florida and becomes more dependent on family for care. Currently, Mr. P’s tasks will be to attempt to live as normal and full a life as possible with his chronic diseases.

The next portion of this paper will involve an analysis of the client/family situation using the intervention piece of the Calgary Family Model. I will discuss the overall thrust of this portion of the model and describe the various parts that I chose to employ with Mr. P. Finally, I will discuss the overall medical and nursing diagnoses and plan of care that I came up with based on these assessments.

Wright and Leahey (2003) begin by discriminating between linear and circular interventive questions. Linear questions are investigative and function to inform the nurse and help gather information; circular questions, on the other hand, reveal a broader understanding of the problem, and are intended to effect behavioral change within the family structure (p. 159-161). Both questions are important during the interview; the authors state that “linear questions

are frequently used to begin gathering information about families' problems, whereas circular questions reveal families' understanding of problems" (p. 160).

Upon reflection of this visit Mr. P, I found examples of both these types of questions. As this was the first home visit I had ever completed, choosing when and how to use them during conversation was unconscious on my part; but as I thought back over the visit, I had employed both at various times. The linear questions were mainly used to complete Mr. P's genogram, as I asked for factual information about ages, dates, etc. But intertwined in this conversation, and throughout the entire visit, were circular questions, as I delved more deeply into the nature of Mr. P's relationships. For instance, I began by asking about his immediate family (both wives and daughters), which mainly involved linear questions. But merely asking about his second wife immediately led to more circular questions about feelings he had related to her death.

The main part of the Calgary Family Intervention Model defines family interventions and why they are important. Wright and Leahey (2000) define a family intervention as "an organizing framework for conceptualizing the intersection between a particular domain of family functioning and the specific intervention offered by the nurse" (p. 157). They describe three different domains of the family in which these interventions are targeted – cognitive, affective, and behavioral (p. 157).

Cognitive interventions are those aimed at offering "new ideas, opinions, beliefs, information, and education" (Wright & Leahey, 2004, p. 165) toward the problem. These include commending family and individual strengths and offering information and opinions (p. 165-168). The affective interventions are more directed at helping clients and families deal with the emotions of the problems that are interfering with attempts at problem-solving. Examples of these interventions are validating or normalizing emotional responses, encouraging the telling of

illness narratives and drawing forth family support (pp. 168-170). Finally, the behavioral intervention section focuses on how family members interact and relate with one another and include the following interventions: encouraging family members to be caregivers, encouraging respite, and devising rituals (pp. 170-171).

In this next section, I will discuss both the medical and nursing diagnoses relevant to this home visit (see Appendices II and III for previous diagnoses). Some of the medical diagnoses from this home visit would be Mr. P's overall chronic conditions, such as DM type II, OA, hyperlipidemia, and nicotine dependence. For these, I did offer several interventions. For instance, regarding his DM and hyperlipidemia, I recommended that he take one aspirin every day based on current guidelines for reduction of cardiovascular risk (Goodman & Uphold, 2003, p. 180). In addition, I also discussed Mr. P's chronic pain issues. We discussed his current regimen of twice-daily Vicodin, and I recommended again that he increase this use to three times a day for better pain control. We had a lengthy conversation where I assured him that he was at a low risk for addiction to this drug, as this was one of his main concerns with increasing the frequency (*Principles of Analgesic Use*, 2003, 39). Also, since Mr. P complained of pain in his lower back pain as a chief source of pain, I would consider adding the medical diagnosis of 'lumbago related to OA' to his chart's problem list. Evaluation of the relief he gets from increasing the Vicodin will be important to assess at his next visit, followed by a further exploration of how to specifically control the back pain (i.e., stretches, etc.). Finally, I discussed Mr. P's use of Elavil with him and how his dry mouth was related to a side effect of the medication. As he said that this had helped considerably with his diabetic neuropathy, I encouraged him to continue taking this and to contact us if he had worsening problems.

I have classified all the above interventions as relating to the cognitive domain of family functioning under the category of offering information. Wright and Leahey (2004) suggest that these particular interventions be done with clear, specific language and easy-to-read literature that is clearly written for the client/family and offered in a non-judgmental way (p. 167). I did write out most of the interventions for Mr. P. Also, I focused on encouraging Mr. P to take the increased Vicodin in a way that made sense to him and allayed his fears about addiction.

Next, I believe that, in the context of this home visit and subsequent interventions, nursing diagnoses, rather than medical diagnoses, will be of the most use to guide the issues that arose during the visit. I have identified several nursing interventions which I feel are appropriate and will be useful to Mr. P's situation: altered oral mucous membranes related to (r/t) need for dentures; altered health maintenance r/t chronic illnesses; activity intolerance r/t to chronic pain and risk for falls r/t occasional unsteadiness while walking; risk for impaired memory r/t occasional forgetfulness observed by provider during interview and stated by client; potential for ineffective breathing pattern r/t continued smoking; interrupted family processes r/t Mr. P's relationship with his eldest daughter; and risk for spiritual distress r/t recent loss of wife, coping with chronic illnesses, and score on depression inventory (Carpenito-Moyet, 2004). I will discuss each one of these diagnoses in certain groupings and their accompanying interventions and plan of care.

The first nursing diagnosis is 'altered oral mucous membranes r/t need for dentures.' Mr. P wears dentures and told me that the lower portion had been broken some time ago. He had originally received his dentures at a facility ("I can't remember where") and was interested in getting new bottom plates. As dental care was not service-connected for Mr. P, he would not qualify for dental care through the VA. As an intervention, I told Mr. P that I would speak to my

preceptor to see if she had any ideas about where he might receive dental care; I also encouraged him to call his insurance company to see if there was any possibility of dental coverage with them. I am planning on discussing this issue with my preceptor during my next clinic day at the VA. We will also be calling Mr. P to have him move his next follow-up appointment from July to May or June so that I can see him before my time at the VA is over. This also falls under the cognitive intervention category of offering information.

I will discuss the next two nursing interventions together: ‘altered health maintenance r/t chronic illnesses’, and ‘activity intolerance due to chronic pain and risk for falls r/t occasional unsteadiness while walking’. The pain that Mr. P experienced both in his legs from diabetic neuropathy and in his back from OA seemed to be what was most debilitating and bothersome to Mr. P about his chronic illnesses. This affects his mobility by not allowing him to do certain things that he loves, or not do them as frequently (such as fishing) and is a potential contributor to his depressed feelings. And upon seeing Mr. P’s stiffness upon arising after sitting for a time and the resulting unsteadiness, I became worried about his risk of falls, especially while living alone. In general, Mr. P is very active and independent, but this may not always be the case.

An article by authors Parks and Hsieh (2002) discusses several areas of preventive health that are important for older adults, among them exercise. The authors cite several evidence-based articles on the topic of exercise which found multiple benefits to patients with OA and joint pain, by decreasing pain, increasing mobility, and ultimately being an important factor in preventing falls and subsequent hip fractures from osteoporosis in older adults (pp. 608-609). They recommend a training program of walking 20-30 minutes three to four times per week, along with balance and strength training (p. 609). I did encourage Mr. P to continue walking as much as possible, which is something he stated he enjoyed doing and could do more now with

the warmer weather. I believe this will be an important factor in contributing to his improved mobility as well as boosting his spirits. I will assess this in further detail at Mr. P's next visit (i.e., openness to use of assistive devices, such as a cane for stability) and also ensure that an increase in Vicodin is not contributing to this risk for activity intolerance or falls in any way.

Next is the nursing diagnosis of 'risk for impaired memory r/t occasional forgetfulness observed by provider during interview and as stated by client'. Based on my observations, Mr. P did not strike me as having a severely or even moderately impaired memory; it seemed to be more an occasional forgetfulness (i.e., not being able to remember certain dates or ages of family members). It may be helpful to further explore this concern, if only to put Mr. P's mind at ease. Authors Park and Hsieh (2002) report that routine screening for mental changes in elderly patients (such as dementia) is most appropriate when there is functional decline and when a family member has noticed a decline in cognition (p. 609). Mr. P may fall into this category with his functional decline, and it would be useful to speak to other family members to further explore this concern.

Nicotine dependence is the next 'chronic' concern of Mr. P that I will only briefly touch on. This is something that we have discussed in detail, and I created a personalized binder for Mr. P from the materials I used for my education presentation. I reinforced my teaching during this home visit, praising Mr. P for his continuing attempts at not smoking and encouraging him to continue. This would fall under the cognitive intervention category of commending strengths. We also discussed reasons that Mr. P wanted to quit, such as quitting before moving to Florida, and I encouraged him to use these goals as guides.

The final grouping is the following two diagnoses, which I consider to be the heart of the visit regarding possible interventions: 'interrupted family processes related to Mr. P's

relationship with his eldest daughter’, and ‘risk for spiritual distress r/t recent loss of wife, coping with chronic illnesses, and score on depression inventory’. I used the affective interventions of validating or normalizing emotional responses and encouraging the telling of illness narratives (Wright & Leahey, 2004, pp. 168-170) by actively listening to Mr. P’s account of feelings surrounding his wife’s death, assuring him that they were normal and appropriate, and encouraging him to talk about how his chronic illnesses have affected his life.

Also, I found Mr. P’s relationships with his daughters to be an area that would benefit from further assessment. It would be helpful during future visits to have more family members present – if not his daughter, then perhaps his sister could lend unique family insights and perspectives. (In hindsight, I wish I had invited his sister and her family to participate in the home visit, as they live close by.) If Mr. P moves to Florida, family dynamics with his daughters will most likely surface, and it would be worthwhile to assess this in further detail and provide Mr. P with some relational skills before his move. Two interventions offered by Wright and Leahey (2004) are drawing forth family support (affective) and encouraging family members to be caregivers (behavioral) (p. 169-170). The first involves “encouraging and assisting family members to listen to each other’s concerns and feelings” (p. 169); the latter discusses family members’ willingness (or anxiousness) to be helpful to members with chronic illnesses (p. 170). These would be interesting and useful interventions to explore with Mr. P and his family.

I was somewhat reluctant during the interview to fully explore how Mr. P felt about his troubled relationship with his eldest daughter and if he would ever like to be on speaking terms with her again; this is something that I will discuss with him at the next visit. Rekindling this relationship and having the chance to know his grandchildren may bring great satisfaction to Mr. P as he grows older. According to a website on Erikson’s stages of intellectual development,

Mr. P should be in the last stage (age 65-death), where a major task is life reflection on both the satisfactions and the failures. However, Mr. P may be stuck in the middle adulthood stage (ages 40-65), where one finds importance in looking outside the self, caring for others (i.e., parenting), creating a living legacy. The article states that the crisis can be solved by becoming invested in the next generation; failing to successfully resolve this crisis can lead to self-centeredness and stagnation later in life (psychology.about.com website, 2005) Reconnecting with his daughter and her family may become an important developmental task for Mr. P.

Finally, I was concerned with Mr. P's score on the Geriatric Depression Scale. Depression is a particular problem with the elderly, and Mr. P is at even higher risk for this due to his wife's recent death and his multiple chronic illnesses. According to Noel, et al, (2004) both the elderly and those with chronic comorbid conditions are at risk for depression; they stated that, by recognizing and treating depression in the elderly, functioning and quality of life improves, despite comorbid conditions (2004). Mr. P was aware that his score placed him in the 'mildly depressed' category; he said he was open to exploring options in this area. My preceptor and I will be exploring this further at Mr. P's next visit. I think addressing this may help improve Mr. P's quality of life as well impacting his familial relationships.

The final section of this paper provides an overall reflection and critique. I found both the Calgary Family Assessment and Intervention Model and Rolland's typology of chronic illnesses to be very helpful during the home visit; they both provided a guiding structure from which to assess the family unit. Although during this visit I was only dealing with one family member, many family issues surfaced, and it would be impossible to separate the impact of Mr. P's chronic illnesses on himself from the effects on his family, as well as the interconnected relationships between all of them. The Calgary Model, although essentially geared toward visits

that would include more than one family member, worked very well for this ‘family of one.’ I believe that it would be useful in many different and nontraditional family situations. I also found the Geriatric Depression Scale to be very useful, and I was glad that I had included this in the interview. Because Mr. P was so cheerful during all his previous visits, I had assumed that he would not be depressed, and I was somewhat surprised at his score on the scale. This was a lesson for me in the importance of not making assumptions based on outward expressions.

This was a very positive experience for me overall. Being a student requires wearing many different hats at various clinical sites. So, while I was very nervous about this experience, I tried to plunge ahead as if this were just another clinical site. Being in Mr. P’s home and hearing his stories was a privilege for me; many of the usual ‘boundary’ issues of the clinic were gone, and I felt that I was able to spend real time getting to know Mr. P. I was reminded that our assessment skills as advance practice nurses never shut off no matter what the situation; there is so much to learn from clients by simply observing them in their own environment.

When I left Mr. P’s house, he walked me to my car and extended his hand for me to shake. Instead, I offered him a hug, to which he replied, “Well, thank you! I haven’t had one of those in a long time.” This, in a way, summed up the entire experience of this home visit for me: The intimacy I often take for granted with my own family was scarce in Mr. P’s life, and this undoubtedly impacted his health and well-being in countless and intricate ways. While providing medically sound, evidence-based care to clients is of the utmost importance, recognizing and incorporating the impact of family on health and well-being is irrefutably essential. The concept of ‘family,’ at least by its modern definition, exemplifies our innate need for human connection, and this human connection is a part of our work that cannot be ignored.

References

- Carpenito-Moyet, L.J. (2004). *Nursing diagnosis: Application to clinical practice* (10th ed.). Philadelphia: Lippincott.
- Erikson's eight stages of human development. Retrieved April 9, 2005, from <http://psychology.about.com/library.weekly/aa091500a.htm>.
- Geriatric depression scale. Retrieved April 5, 2005, from <http://www.jr2.ox.ac.uk/geratol/GDSdoc.htm>.
- Goodman, J.J., & Uphold, C.R. (2003). Diabetes mellitus. In C.R. Uphold & M.V. Graham (Eds.), *Clinical guidelines in family practice* (4th ed.) (pp. 164-193). Gainesville, FL: Barmarrae Books, Inc.
- Noel, P.H., Williams, J.W., Unutzer, J, Worchel, J., Lee, S., Cornell, J., et al. (November, 2004). Depression and comorbid illness in elderly primary care patients: Impact on multiple domains of health status and well-being. *Annals of Family Medicine*, 2(6), 555-562.
- Parks, S.M., & Hsieh, C. (September 1, 2002). Preventive health care for older patients. *Primary Care*, 29(3), 599-614.
- Principles of analgesic use in the treatment of acute pain and cancer pain* (5th ed). (2003). Glenview, IL: American Pain Society.
- Rolland, J.S. (1994.) *Families, illness, and disability*. New York, NY: BasicBooks.
- Uphold, C.R. (2003). Osteoarthritis. In C.R. Uphold & M.V. Graham (Eds.), *Clinical guidelines in family practice* (4th ed.) (pp. 836-840). Gainesville, FL: Barmarrae Books, Inc.
- Wright, L.M., & Leahey, M. (2000). *Nurses and families: A guide to family assessment and intervention* (3rd ed.). Philadelphia: F.A. Davis Company.

N666 Scholarly Paper

Family and Individual Perspectives on Coping with Chronic Illness Paper: A Theoretical Approach to Care of Chronically Ill Adults and their Families

Purpose: Chronic illness affects both the individual and the family since it has an impact on every aspect of a person's being (emotional, physical, spiritual, financial, social). Mgt of health care of pts w/ chronic conditions requires an understanding of the individual and family factors that influence the pt's health and response to care. Inclusion of the family in mgt or as a focus of the intervention is important for the success of care. In order to provide comprehensive, holistic care to pts, primary care NPs need to provide care from a theoretical base that includes both individual and family component. The rdgs by Rolland, Miller, and Wright and Leahey describe issues r/t chronic illness as well as specific ways to assess and intervene with pts and families. Specific models addressed include the Calgary Family Assessment and Intervention Model (Wright and Leahey) and Rolland's Model of Family Adaptation to a Chronic Illness.

Assignment: Given this background, select a client you have seen both in the clinic and visited in the home this term. You need to make at least one home visit to this ct. You will incorporate this home visit into your paper. The home visit is meant to provide you with a more comprehensive picture of the client and family's response to the illness and the illness's impact on both the client and the family than can be obtained in the clinic setting.

1. Describe the client and family. Include a family genogram that addresses significant life events as well as illnesses/diagnoses with your description. (at least 3 generations)
 - Client is a 68 yo white male with following chronic conditions:
 - o Diabetes Type II with Peripheral Neuropathy
 - o Osteoarthritis
 - o Chronic Pain r/t OA and neuropathy
 - o Nicotine Dependence
 - o Hyperlipidemia
 - Family Situation
 - o Wife – deceased since 2003
 - o Sister – visits frequently
 - o Brother – lives in California
 - o Daughter – lives in Tennessee; has close relationship
 - o Daughter – lives in Florida; hasn't talked to for a long time

2. Provide a succinct summary of the family approach you are using to work with this family. You are not expected to apply all components of the models with your client.

- Family Assessment
 - Structural
 - Internal
 - Family composition
 - Gender
 - Sexual orientation
 - Rank order
 - Subsystems
 - Boundaries
 - External
 - Extended family
 - Larger systems
 - Context
 - Ethnicity
 - Race
 - Social class
 - Religion and spirituality
 - Environment
 - Developmental
 - Stages
 - Tasks
 - Attachments
 - Functional
 - Instrumental
 - ADLs
 - Expressive
 - Emotional communication
 - Verbal communication
 - Nonverbal communication
 - Circular communication
 - Problem solving
 - Roles
 - Influence and power
 - Beliefs
 - Alliances and coalitions

- Family Intervention – An organizing framework for conceptualizing the intersection between a particular domain of family functioning and the specific intervention offered by the nurse
 - Interventions – targeted to promote, improve, and sustain effective family functioning in following domains
 - Interventive Questions
 - Linear – inform the nurse, investigative, gather info; intended to correct behavior
 - Circular – meant to effect change; reveal understanding of problem; intended to facilitate behavioral change
 - Domains of family functioning
 - Cognitive – beliefs; offer new ideas, opinions, beliefs, info, or education on specific health problem or risk
 - Commending family and individual strengths
 - Offering information and opinions
 - Affective – designed to reduce or increase intense emotions that may be blocking problem-solving efforts
 - Validating or normalizing emotional responses
 - Encouraging the telling of illness narratives
 - Drawing forth family support
 - Behavioral – help family members to interact and behave differently in relation to one another
 - Encouraging family members to be caregivers
 - Encouraging respite
 - Devising rituals
 - “Fit,” or effectiveness
 - Can ‘offer’ interventions only
 - Depends on family make-up and interactions, relationship to nurse, her ability to invite family to reflect about their health problems
 - Involves recognition of reciprocity between the nurse’s ideas and opinions and the family’s illness experience

3. Apply Rolland's typology of chronic illness to the client/family situation you selected. Refer to the Rolland article to consider the illness type, the time phase of the illness, and the components of family functioning in your description.

Psychosocial Types of Illness	Diabetes Type 2	Osteoarthritis
<i>Onset</i>	Gradual	Gradual
<i>Course</i>	Progressive – Slow (Possibly Constant)	Progressive – Slow
<i>Outcome</i>	Nonfatal (Possibly fatal/shortened life span)	Nonfatal
<i>Incapacitation</i>	Non-Incapacitating	Incapacitating
<i>Predictability</i>	Predictable (Possibly Unpredictable)	Predictable
Symptom Visibility	Hypo- or Hyperglycemia; mostly invisible	Pain (subjective), decreased activity
Likelihood and severity of crises	Hypoglycemia	Flare-ups
Genetic Contribution	High	Moderate
Treatment Regimens	Complicated	Relatively simple
Age at onset	Elderly	Elderly

- Time Phase of the Illnesses
 - o Crisis – any symptomatic period before diagnosis and initial period of readjustment and treatment; requires **increased** family cohesion
 - Tasks:
 - Create a meaning for the disorder that preserves a sense of mastery
 - Grieve the loss of the pre-illness family identity
 - Accept permanency of the condition
 - Undergo short-term crisis reorganization, while developing family flexibility in the face of uncertainty and threatened loss
 - Learn to live with illness-related symptoms and tx's
 - Forge a working relationship with professional and institutions
 - Framing Event – crucial to adaptation to disease
 - Family members' initial expectation of whether a disease is likely to cause death and the degree to which they experience anticipatory loss
 - Advice given at the time of diagnosis
 - Key Family Tasks
 - See itself as a functional unit to deal with issues
 - Gain understanding of illness in terms of course, developmental tasks
 - Creates a meaning for illness that maxes a sense of mastery and competence
 - May have to put other life plans on hold to accommodate; requires greater family cohesion

- *Chronic or 'Long Haul' Phase* – constancy, progression or episodic daily demands; demands **less cohesion** of family member
 - Issues
 - Pacing and avoiding burnout
 - Relationship skews b/w pt and other family members
 - Preserve or redefine individual/family goals w/i illness limits
 - Sustain intimacy in face of threatened loss
 - Key Family Tasks
 - Maintain semblance of normal life under abnormal conditions and uncertainty
 - Transition emphasizes autonomy and the creation of a viable on-going life structure in r/t realities of illness
 - Developmental tasks of living with chronic condition and living the other parts of life need to be brought together
 - Maintaining max autonomy of all family members despite pull toward mutual dependency and caregiving
- *Terminal Phase* – the inevitability of death dominates family life; family copes w/ issues of separation, death, mourning, and family reorganization beyond loss; families adapt best when they are able to shift from trying to control the illness to a successful process of letting go; demands **greater cohesion** and pulling inward of family members
 - Optimal Coping – emotional openness and dealing with practical tasks
 - Share precious time together
 - Acknowledge impending loss
 - Deal w/ unfinished business
 - Say goodbyes
 - Begin process of family reorganization
 - Key Family Tasks
 - Shift from anticipation to probability of terminal phase and inevitability
 - Hopes for cure and long-term survival are relinquished
- *Transition periods* b/w the 3 time phases are critical for individual and family adaptation
 - Turning points when families re-evaluate fit of their previous life structure with development demands of the new illness
 - Transition b/w acute and chronic phases is most significant time to create the plan for living with the chronic condition
 - Unfinished business can complicate or block movement forward and families can become stuck (i.e., the usefulness of pulling together in the crisis phase can become maladaptive during a long chronic phase)

4. Using the Wright and Leahey text, and Rolland's article, analyze the client/family situation using a family approach. Describe how it applies to the client/family's situation. How did it guide your assessment, diagnoses, and management plan? Include any assessment tools utilized and the rationale for their use with this client.
5. Based on this analysis, identify nursing and medical diagnoses appropriate to the individual and family situation, develop a comprehensive, family-focused plan of care and provide expected outcomes. Critique your plan of care with this client and his family.
6. Finally, critique the family approach and any assessment tools you may have used. Consider how a family focused plan of care differs from one developed solely for the individual client? How did it influence your management? How has this changed your approach to health history and view of clients with chronic disease? Are there questions you would now include in a health history of individuals with chronic disease? Give rationale for these. Discuss the limitations of the family model/s used in your paper in primary care practice. (Is it relevant to diverse groups culturally and in terms of broad definitions of families? Would it be as relevant to a gay family, or a single-parent family? How does it address aging clients who live alone?)
7. Quality of writing. The paper should demonstrate evidence of graduate level writing. References must be current, relevant, and comprehensive. APA format. 15-20 pages.

Grading Sheet

1. Description of the general client/family situation
 - a. Family genogram
 - b. Unique family situations
 - c. Home visit revelations/insights
2. Analyze the client illness/family situation using Rolland's typology (illness type, time phase, etc.) Discuss the impact of this illness on the client, family with subsequent responses.
3. Summary of components of family model used. Describe how it applies to the client/family situation. How did it guide your assessment, diagnoses, and management plan? Include any assessment tools utilized and the rationale for their use with this client.
4. Diagnoses and Management – Analyze the client/family situation using a family approach for chronic illness interventions. Develop a comprehensive, family focused plan of care based on this analysis and include medical and nursing diagnoses.
5. Expected Outcomes with Evaluation Criteria and Timelines
 - a. Measurable and appropriate
 - b. F/u and/or referral
6. Critique of Rolland's typology and the family model used
 - a. Discuss strengths and limitations of this approach. Critical thinking skills should be clearly demonstrated. Critique assessment tools used for family and client.
7. APA format
 - a. References are current, relevant, and comprehensive
 - b. Evidence of graduate level writing skills
 - c. Assessment tools and SOAP note

Questions to Ask:

1. When and how did your wife die? What was your relationship like with her? For how long had you been married? Any relationships since then?
2. Daughters' families
3. What has been your experience of living with diabetes and chronic pain of neuropathy and OA? When were you diagnosed with these? How are they managed? Are you satisfied with this plan? How has it impacted your life? Your family's life/lives? How did you first react upon diagnosis? How about your family?
4. Course (progressive vs. constant vs. episodic/relapsing) - What info has the medical team given you about the expected course of your condition? What were you told about how uncertain the course could be? Address discrepancies.
5. Outcome (fatal vs. possibly fatal/shortened life span vs. nonfatal) – What have you been told about your prognosis? Do you think this illness can or will shorten your life? If so, when do you think this could happen? Do your views differ from what you have been told by your PCP? If so, how is this difference managed? Is there agreement about the prognosis within this family? If there is disagreement within the family, who disagrees with whom, and how are differences of opinion handled?