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A Message from the President

Dear AANLCP Members,

As spring brings renewal and fresh perspective, our spring journal offers us a meaningful opportunity to reflect and focus on the evolving needs of the populations we serve—particularly our aging clients. This journal edition supports the important work you do every day to support older adults and their life care plans in striving for dignity, safety, quality of life, and improved health.

With increasing longevity and complexity of health conditions, our role as nurse life care planners has never been more vital. You bring not only clinical expertise, but also important attributes like compassion, advocacy, and foresight to individuals and their families. This helps them in projecting their ongoing needs as they traverse some of life's most challenging transitions.

In this issue, we highlight emerging trends, best practices, and thoughtful approaches to caring for older adults. From long-term care planning to the integration of interdisciplinary resources, your work shapes better outcomes and more informed decision-making across the continuum of the life care plan.

I pray you all are having a great spring and getting ready for the dog days of summer, which are close upon us.

Thank you for your dedication, your expertise, and your unwavering commitment to those you serve.

Warm regards,

Craig
President, AANLCP

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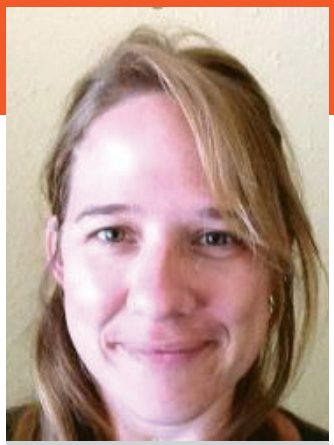
President, AANLCP 2026 | president@aanlcp.org

From the Editor



Vanessa Richie
JNLCP Editor
journal@aanlcp.org

Now that we are well into spring, most of us have settled into the chaotic schedule that comes with the end of the school year and planning for summer. Spring also seems to be particularly busy when it comes to workload – one project closes, two more open. The days are longer, which often translates into thinking we've got a few more hours to get more work done. What we should be doing is going outside to enjoy it while the flowers are still in bloom and the temperatures are generally pleasant.

During busy times, like spring, preparing life care plans can be difficult because of the volume of work. Taking everything into account for the client's current needs is typically already complex. Thinking about what clients will need decades into the future, especially in the presence of expected senescence and aging, can seem challenging. This issue provides some details about topics and possible solutions to help you deal with this problem.

From physical decline that increases the risk of injury to mental issues that are far less predictable, there is a lot to consider when planning for a client's golden years. Several of our articles provide different perspectives on planning for a person's physical needs. This includes different assessments that can be conducted to monitor your client's physical decline. A couple of other articles provide information on mental health assessments for the many different ailments and problems that may arise, but are far less predictable than physical decline. Several articles also touch on providing support and resources to alleviate social issues that older adults are more likely to face.

May you have a fantastic spring with a little bit of planning to relax as we move into the warmer months.

Cheers,

Vanessa Richie, Editor

Information for Authors

Information for Authors

AANLCP® invites interested nurses and allied professionals to submit article queries or manuscripts that educate and inform the Nurse Life Care Planner about current clinical practice methods, professional development, and the promotion of Nurse Life Care Planning. Submitted material must be original. Manuscripts and queries may be addressed to the Editor. Authors should use the following guidelines for articles to be considered for publication.

Text

- Manuscript length: 1500-3000 words
- Use Word© format (.doc, .docx) or Pages (.pages)
- Submit only original manuscript not under consideration by other publications
- Put the title and page number in a header on each page (using the Header feature in Word)
- Place author name, contact information, and article title on a separate title page
- Use APA style (Publication Manual of the American Psychological Assoc. current edition)

Art, Figures, Links

- All photos, figures, and artwork must be in JPG or PDF format (JPG preferred for photos).
- Line art must have a minimum resolution of 1000 dpi, halftone art (photos) a minimum of 300 dpi, and combination art (line/tone) a minimum of 500 dpi.
- Each table, figure, photo, or art must be submitted as a separate file, labeled to match its reference in text, with credits if needed (e.g., Table 1, Common nursing diagnoses in SCI; Figure 3, Time to endpoints by intervention, American Cancer Society, 2019). Graphic elements embedded in a word processing document cannot be used.
- Live links are encouraged. Please include the full URL for each.

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Manuscript Review Process

Submitted articles are peer reviewed by Nurse Life Care Planners with diverse backgrounds in life care planning, case management, rehabilitation, and nursing. Acceptance is based on manuscript content, originality, suitability for the intended audience, relevance to Nurse Life Care Planning, and quality of the submitted material. If you would like to review articles for this journal, please contact the Editor.

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Contributors to this Issue

Dr. Allison Weiner-Lasher, DPT, OTR/L

Dr. Allison Weiner-Lasher has been practicing as a physical and occupational therapist for the past twenty years. With diverse experience in major NYC hospitals in both inpatient and outpatient settings, serving adult, pediatric, orthopedic, and neurological populations, Dr. Weiner-Lasher provides valuable clinical expertise. In addition to clinical work, Dr. Weiner-Lasher worked as a professor in the Physical Therapy doctorate program at Hunter College in New York City. She continues to practice clinically as an occupational and physical therapist in the New York and New Jersey region.

Dr. David Demarest, PhD, CBIST

Dr. David Demarest received his Doctoral degree in Clinical Psychology from West Virginia University in 1993, with an emphasis in Neuropsychology and rehabilitation. He completed a specialty internship in Neuropsychology and rehabilitation at the University of Oklahoma Health Sciences Center in 1994 and a specialty post-doctoral fellowship in Neuropsychology and rehabilitation at the University of Missouri Medical School and Rusk Rehabilitation Center in 1995. He has been involved in working with individuals with central nervous system dysfunction, including acquired brain injury, spinal cord injury, Alzheimer's and other Dementias, progressive neuromuscular conditions (such as Cerebral Palsy), developmental disorders in childhood (Autism Spectrum Disorders, Attention-deficit/Hyperactivity Disorder, Specific Learning Disorders), and other related disorders, for over 30 years. He is a Licensed Psychologist, a Clinical Neuropsychologist, and the Director of Psychology, Neuropsychology, and Clinical Counseling Services at On With Life in Ankeny, Iowa. He has served on the Iowa Governor's Advisory Council for Brain Injury. His Independent Evaluation program was the first such program to be nationally accredited by the Commission on the Accreditation of Rehabilitation Facilities. He has co-written the BIAUSA chapter on Disorders of Consciousness for the Certified Brain Injury Specialist training and is a CBIS Trainer.

Dr. Dave Anders, MS, CCC-SLP, CBIST-AP

Dave is a licensed speech-language pathologist and educator in Iowa who has been practicing in the field of brain injury rehabilitation since 1997. He has been a certified brain injury specialist since 2004 and has earned both the CBIS Trainer and Advanced Practice designations. Dave is a member of the board of directors for both BIAA's Academy for the Certification of Brain Injury Specialists and the Brain Injury Association of Iowa. Dave has presented regionally, nationally, and internationally on a wide range of topics related to brain injury. Dave serves as the chief clinical officer at On With Life. He has authored several works over the years

Contributors to this Issue

Victoria Powell, RN, CCM, LNCC, CNLCP®, CLCP, MSCC, CBIS, CEASII

Victoria Powell is a registered nurse and the current President of VP Medical Consulting, LLC. VP Medical Consulting offers a variety of services for catastrophically injured or chronically ill individuals such as case management, patient advocacy, life care planning, bill review and more.

Ms. Powell is an active member of the American Association of Nurse Life Care Planners (previously serving as President), American Association of Legal Nurse Consultants, Case Management Society of America, International Academy of Rehab Professionals, and is a lifetime Hall of Fame Recipient for her contributions to the National Nurses in Business Association. Ms. Powell provides expert witness testimony in the area of life care planning. Powell has a lifelong dedication to learning and holds specialty certifications in Case Management, Legal Nurse Consulting, Life Care Planning, Medicare Set Aside, and Ergonomic Assessments.

Powell's company, VP Medical Consulting, is made up of experienced nurses, board certified patient advocates, and support staff working together. The team is focused on comprehensive care to improve the lives of those with injuries or illness and to support the family caregivers. Sge is also the founder of Remington Publishing, which produces books, tools, and resources for medical-legal professionals. Ms. Powell has been published in numerous professional journals, has authored and contributed to textbooks in the field.

Ms. Powell is a nationally recognized speaker and regularly presents on a variety of nursing related subjects. Interested parties may contact Powell by emailing Victoria@vp-medical.com.

Brandie Vaughter, BCPA, CAC, CBIS, CDP

Brandie Vaughter is a Board-Certified Patient Advocate with over 20 years of experience guiding individuals and families through complex healthcare, financial, and end-of-life decisions. She is a Certified Brain Injury Specialist, Certified Dementia Practitioner, and Certified Alzheimer Caregiver, with a background as a certified medical biller and coder.

Raised in South Texas, Brandie's call to serve senior adults began early. During summer breaks, she volunteered at a local nursing home alongside the activities director and later served as a caregiver for her grandmother, who lived with Alzheimer's disease. These formative experiences shaped her lifelong commitment to elder advocacy, which she considers her God-given spiritual gift. Although her formal education was in pre-veterinary studies and equine management, Brandie ultimately felt led to devote her life's work to serving senior adults and vulnerable populations.

Brandie has spent the past two decades with VP Medical Consulting as Chief Financial Officer, working in workers' compensation, life care planning, Medicare Set-Asides, and patient advocacy. She assists patients daily with Medicaid applications, VA benefits, housing decisions, fiduciary matters, and end-of-life planning, often serving as Power of Attorney, Fiduciary, VA Fiduciary, Trustee, or Executor. She has served on the Arkansas Medicaid Client Voice Council, most recently as Chairman, and on the Arkansas Medicaid Advisory Council. Brandie and her husband, Bryant, are also active at New Life Baptist Church, serving in various ministries.

Contributors to this Issue

Sarah O' Connor BSN, RN, GERO-BC, WCC, CDP

Sarah O'Connor has nearly 17 years of nursing experience, with a focus on long-term care, assisted living, memory care, and wound care. She is board-certified in gerontological nursing and holds additional certifications in wound and dementia care. She serves on a Resident Care and Compliance Committee for a senior living community offering skilled nursing, memory care, and personal care.

Based in Pennsylvania, Sarah is the owner of Sarah O'Connor Legal Nurse Consulting, where she provides clinical review, analysis, and insight for cases involving long-term care and assisted living. She remains actively involved in direct care within assisted living. She also provides care management consultation and clinical guidance, supporting older adults and their families with care navigation and planning.

Sarah's work is grounded in the belief that elder care cases require an understanding of both clinical complexity and the realities of caregiving environments. Caring for older adults has remained a meaningful focus throughout her nursing career, shaping her approach to quality of care, clinical review, and the unique challenges affecting long-term care settings

Becky Czarnik, RN, MS, CNLCP®
Founder & Principal Nurse Life Care Planner, Sierra Nurse Consultants

Becky Czarnik brings over 40 years of nursing experience to her role as a Certified Nurse Life Care Planner and Certified Legal Nurse Consultant. As the founder and principal of Sierra Nurse Consultants, she leads a practice focused on life care planning, medical cost projections, and expert witness services in cases involving complex medical and legal issues.

With a BSN from St. Olaf College and a Master of Science from The Ohio State University, Ms. Czarnik's career has spanned intensive care, hospital leadership, home health, and community-based care in diverse settings across the country. This comprehensive background has given her a deep understanding of the full continuum of care—knowledge she now applies to developing future care plans that are both clinically accurate and legally sound.

As a mentor and educator, Becky is committed to supporting the next generation of nurse care planners. She currently serves as Education Chair for the American Association of Nurse Life Care Planners (AANLCP), where she contributes to curriculum development, national conference programming, and professional standards. She contributed to the AANLCP Scope and Standards of Practice and continues to publish and present on best practices in nurse consulting.

Becky encourages nurses to recognize the unique value of their clinical expertise in non-traditional roles. She believes that life care planning is not only a natural extension of nursing judgment and advocacy, but also a powerful opportunity to impact patients' futures beyond the bedside. Her work and mentorship aim to elevate the role of nurses in the legal arena and support colleagues transitioning into this specialized field.

Contributors to this Issue

Karla Rodriguez, DNP, RN, CNE, NC-BC, DipACLM, FNYAM

Karla Rodriguez teaches in the undergraduate nursing program and brings a diverse clinical background spanning both adult and pediatric populations, with a strong focus on medical-surgical care. She also teaches an undergraduate elective in lifestyle medicine, reflecting her commitment to preventive, evidence-based approaches to health and wellness. She actively collaborates and networks with interdisciplinary healthcare professionals who share an interest in lifestyle medicine, promoting holistic care across settings.

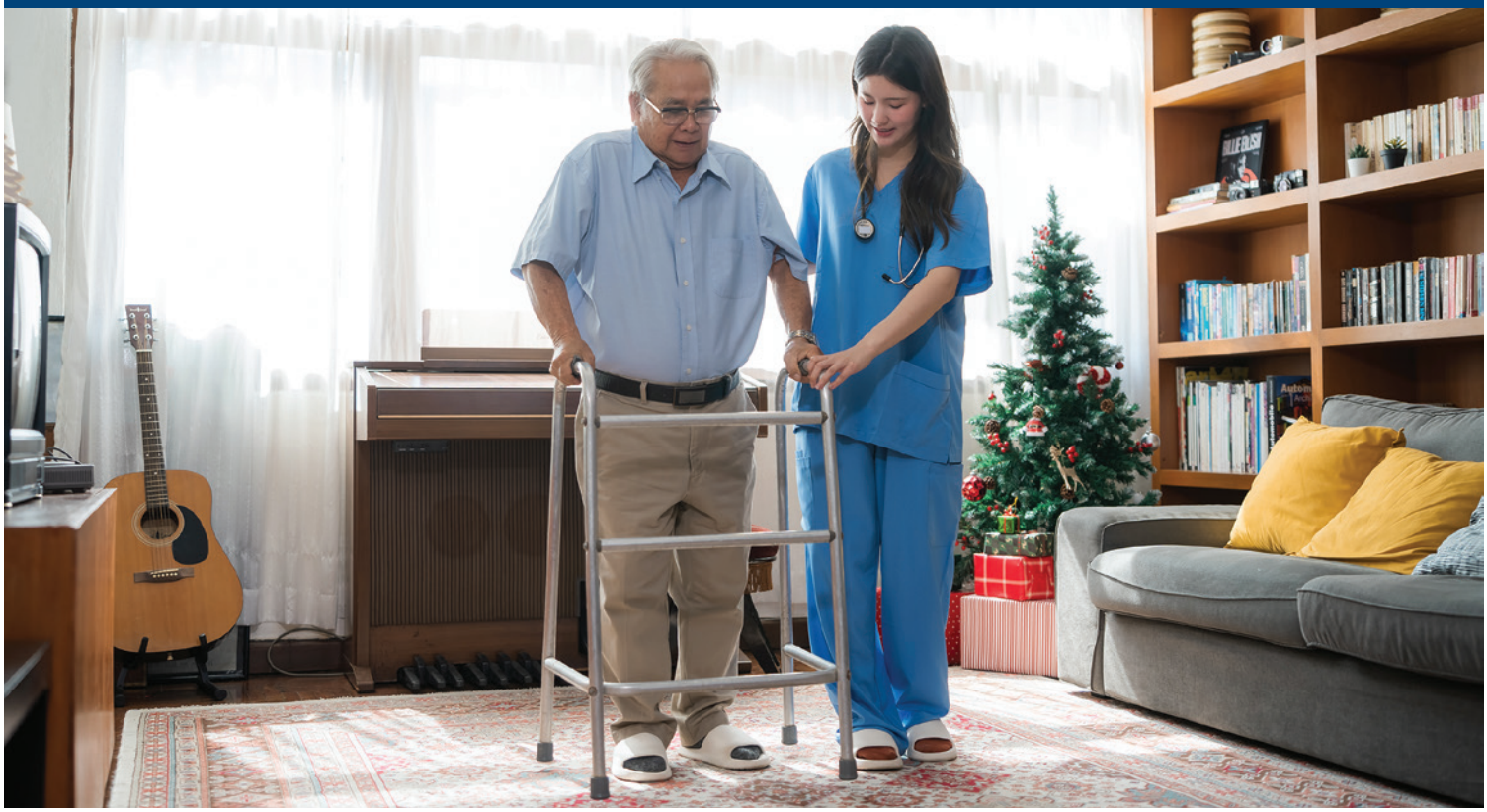
Her involvement with the National Association of Hispanic Nurses – New York Chapter reflects her dedication to advancing diversity, leadership, and professional development in nursing. She also serves on the nominating committee for the National Association of Hispanic Nurses, contributing to leadership selection and organizational governance at the national level.

She is an Integrative Health Nurse Coach whose focus is on expanding Integrative Health approaches to well-being and healing for providers, people, and communities.

AGE-RELATED BALANCE AND STRENGTH DECLINE IN THE OLDER ADULT

An Integrated Physical and Occupational Therapy Perspective for Nurse Life Care Planning

By: Dr. Allison Weiner-Lasher, DPT, OTR/L



Keywords: Aging Process, PT/OT Assessment, Functional Decline

NURSING DIAGNOSES TO CONSIDER
NANDA-I 2024-2026

1. Risk for Falls 2. Risk for Elder Frailty Syndrome 3. Risk for Decreased Self-Care Ability Syndrome

Introduction

The aging process is associated with predictable physiological changes that affect balance, strength, gait, endurance, neuromuscular reflexes, and functional performance. These changes occur even in the absence of acute injury or diagnosed pathology. They also have significant implications for safety, independence, and future care needs in older adults.

Nurse life care planners are frequently tasked with projecting long-term care requirements for aging individuals whose functional abilities may decline over time. Physical and occupational therapy evaluations provide objective, functional data that are critical to accurate life care planning.

This article examines common age-related changes in balance, strength, gait, and activities of daily living from an integrated rehabilitation perspective. Standardized functional assessments commonly used in clinical practice are reviewed, contemporary normative values are discussed, and practical strategies for interdisciplinary collaboration are presented to support defensible projections of future care needs in elder life care planning.

The Role of Therapy in Functional Decline

The population of older adults in the United States continues to grow, resulting in increased demand for accurate and comprehensive long-term care planning. As individuals age, gradual declines in physical function often lead to reduced independence, increased fall risk, and greater reliance on supportive services. While medical diagnoses provide important information, they do not always capture the functional implications of age-related decline that affect daily life. This article focuses on predictable and functional decline in older adults rather than disease-specific impairments, although comorbid conditions may accelerate these changes and influence the trajectory of care needs, such as physical and occupational therapies.

Physical therapy focuses on movement, balance, strength, gait, and endurance, while occupational therapy examines how these impairments affect the performance of activities of daily living (ADL) and instrumental activities of daily living (IADL). Together, these rehabilitation perspectives provide a comprehensive understanding of functional capacity and safety in older adults. Even individuals considered to be "aging normally" may demonstrate functional decline that significantly impacts independence. Failure to account for these predictable changes can result in underestimation of future care needs in a life care plan (Figure 1 and Figure 2).

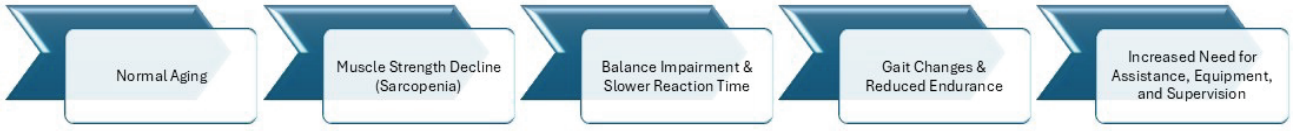
Trajectory of Normal Aging

Aging is associated with physiological changes that affect multiple body systems. Many of these changes occur independent of disease or injury and can significantly impact functional mobility and safety. Rehabilitation professionals frequently observe functional decline that does not meet criteria for a specific medical diagnosis, yet meaningfully limits independence.

One of the most significant age-related changes is sarcopenia, the progressive loss of muscle mass and strength. The cause of sarcopenia is multifactorial due to hormonal changes, inflammatory pathway activation, decline in activity, chronic illness, poor diet, and fatty infiltration as a person ages.

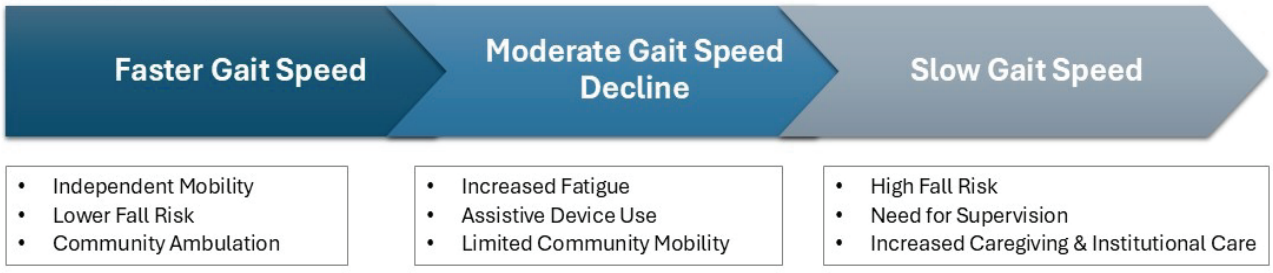
Muscle strength is defined as the maximal force a muscle can produce, while muscle power incorporates both force and the speed at which that force is generated. Because power is the product of force and velocity, reductions in strength reduce the capacity to generate power. In aging adults, loss of strength combined with slowed neuromuscular activation results in disproportionately greater declines in power, which has a more direct impact on functional mobility and fall risk. Muscle strength does not decline steadily; it tends to decline more rapidly in the later decades of life, affecting muscle power, which is critical for balance recovery, transfers, and ADL.

Figure 1: Age-related progression of functional decline and its implications for Nurse Life Care Planning.
Adapted from concepts described by the National Institute of Aging (2022).



Functional decline often precedes loss of independence

Figure 2: Conceptual relationship between gait speed, functional independence, and anticipated care needs in older adults.
Based on Studenski et al. (2011).



Gait speed is a functional vital sign predictive of morbidity and mortality

Lower extremity weakness contributes to difficulty with sit-to-stand transfers, stair negotiation, balance recovery, and ambulation. From an occupational therapy perspective, reduced strength also interferes with daily activities such as bathing, dressing, toileting, and overall household mobility.

Strength Decline and Functional Consequences

Strength decline is a primary contributor to loss of independence in older adults. Physical therapists commonly document weakness in the hip extensors, hip abductors, quadriceps, ankle plantar flexors, and trunk musculature—muscle groups essential for transfers, gait, and balance recovery.

Muscle Groups Critical for Transfers, Gait, and Balance

Hip extensors generate force for sit-to-stand transfers and stair climbing. Aging-related loss of muscle power limits rapid force production, increasing reliance on arm support or caregiver assistance. Hip abductor weakness compromises pelvic stability during gait, resulting in slower and impaired walking speed and reduced endurance. Quadriceps weakness impairs controlled standing and stair negotiation, while plantar flexor decline reduces push-off power and the ability to take a protective step following balance loss. Trunk weakness further limits postural control and movement efficiency.

Physiologically, these changes reflect a combination of sarcopenia, reduced motor unit recruitment, slowed neuromuscular firing, and diminished muscle power. Although each contributes to a decline in an individual's independence, muscle power declines more rapidly than strength and is particularly important for fall prevention and safe mobility.

Upper Extremity and Functional Strength Decline: An Occupational Therapy Perspective

From an occupational therapy perspective, age-related strength decline significantly affects upper extremity function and the ability to perform ADL and IADL, resulting in a self-care deficit. Declines in hand and shoulder strength frequently determine whether an individual can complete self-care tasks independently or if they require assistance.

Grip strength is a widely accepted indicator of functional strength and overall health status (Mayhew et al., 2023). Grip strength is typically measured using a handheld dynamometer. Average grip strength is approximately 75–100 pounds in men and 45–65 pounds in women in early adulthood (ages 20 to 39) and declines progressively with age. Among adults aged 60 to 65 years and older, grip strength below approximately 57 pounds in men and 35 pounds in women is associated with functional limitation and increased disability risk (Mayhew et al., 2023).

Upper extremity strength, which includes grip, affects the ability to manage clothing fasteners, open containers, use of utensils, use of grooming items, and medication management. Reduced shoulder and arm strength limits bathing, dressing, toileting, and overhead tasks. Upper extremity weakness compromises an individual's ability to grasp handrails or maintain a secure hold on mobility aids during transfers, which increases the risk of falls (Jiménez-García, López-Torres, & Rodríguez-Almagro, 2024).

From a life care planning perspective, progressive upper extremity strength decline supports projections for increasing personal care assistance, adaptive equipment use, task modification, and caregiver support.

Neuromuscular Reflex Changes and Safety Implications in Aging

Neuromuscular reflexes are automatic responses that allow the body to react quickly to changes in position or balance. In younger adults, sensory input from the feet, joints, and inner ear is rapidly processed, and corrective muscle responses occur almost immediately. With normal aging, this process slows down. Nerve conduction velocity decreases, sensory input becomes less precise, and muscle activation is delayed, reducing the ability to recover balance before a fall occurs.

Several reflexes are commonly affected by aging:

- The ankle strategy – This reflex helps to stabilize a patient's balance during small surface changes or smaller perturbations, for example, if a person were bumped into while walking. It becomes less effective with age due to delayed activation and weakness.
- The protective stepping response – This response is assessed by observing if the patient can take a quick and stabilizing step when balance is thrown off. It is required to prevent falls during larger balance disturbances, and often, with age, it is slowed and poorly executed.
- Righting reflexes – Delayed righting reflexes, which realign the head and trunk during movement, increase the risk of falls during transfers and stair negotiation.

From a life care planning perspective, delayed neuromuscular reflexes and delayed postural responses significantly increase fall risk. These predictable changes support recommendations for supervision, environmental modification, assistive device use, and proactive fall prevention strategies.

Age-Related Balance Changes and Balance Assessment

Balance requires integration of sensory input, neuromuscular control, and musculoskeletal strength. Normal aging affects all components of the balance system, resulting in increased postural sway, delayed balance reactions, and reduced

ability to recover from perturbations. Occupational therapy assessments frequently identify balance-related safety risks during ADL and IADL, including toileting, shower transfers, meal preparation, and household mobility (National Institute on Aging, 2022).

Tinetti Gait and Balance Assessment Tool

The Tinetti Gait and Balance Assessment is a widely used standardized tool to evaluate balance in older adults. The balance component evaluates sitting balance, rising from a chair, immediate standing balance, standing balance with eyes closed, response to a gentle nudge, turning, and controlled sitting (Scura, 2022). The balance subsection is scored out of 16 points. Scores of 13–16 indicate low fall risk, 9–12 signify moderate fall risk, and 8 or below are indicative of a high fall risk.

From a life care planning perspective, moderate to high fall risk scores support recommendations for supervision, fall prevention strategies, environmental modification, and caregiver assistance.

Four-Stage Balance Test

The Four-Stage Balance Test is an assessment tool that screens individuals for fall risks (Centers for Disease Control and Prevention, 2023). The test consists of four standing positions—feet together, semi-tandem, tandem, and single-leg stance—each held for up to 10 seconds without upper extremity support. Inability to maintain a tandem stance for 10 seconds is associated with increased fall risk.

Poor performance on this test indicates difficulty maintaining balance during standing tasks such as showering, dressing, and reaching. These findings support life care planning recommendations for environmental modification and supervision during standing activities.

Gait and Functional Mobility Assessment

Gait assessment is a core component of physical therapy evaluation and provides essential information regarding safety and independence. Physical therapists assess posture, step length, cadence, base of support, turning, and assistive device use.

Gait Speed Assessment

Gait speed reflects combined strength, balance, endurance, and neuromuscular control. It is commonly assessed over 10–20 feet at a comfortable pace. Individuals walking at approximately 3.5–4 feet per second generally demonstrate safe community mobility, while speeds closer to 2 feet per second or slower are associated with increased fall risk, reduced endurance, and greater need for supervision (Studenski et al., 2011; Mayhew et al., 2023). The Timed Up and Go test assesses this functionally.

Timed Up and Go Test

The Timed Up and Go test, often referred to as the TUG test, is a functional mobility assessment incorporating transfers, gait, turning, and balance. The test measures the time required to stand from a chair, walk approximately 10 feet, turn, return, and sit. Prolonged times are associated with increased fall risk and reduced functional independence (Mayhew et al., 2023).

Falls as a Predictor of Functional Decline

Unintentional falls are the leading cause of injury and death from injury among adults who are 65 years and older. Falls often represent a transition from independence to increased care needs. Even non-injurious falls may lead to fear of falling, activity restriction, and deconditioning. Damaging falls frequently precipitate the need for caregiver assistance or supervised living.

Rehabilitation Evaluation and Standardized Outcome Measures in Life Care Planning

Standardized assessments allow rehabilitation professionals to objectively document functional status and anticipate decline. Measures of balance, strength, mobility, and functional ADL performance provide support for life care plan recommendations related to assistive devices, supervision, therapy services, and caregiver hours.

A life care planner during the assessment visit can also rely on a framework developed by the CDC: Stopping Elderly Accidents, Deaths, and Injuries program (STEADI). STEADI is a multipart exam with both subjective and objective information. It includes screening questions (Have you fallen in the past year?), risk assessment, interventions, and functional tests, which include the 30-second chair stand and the TUG and 4-stage balance tests previously discussed (n.d.).

Collaborating With Physical and Occupational Therapists to Anticipate Decline

Effective nurse life care planning should include collaboration with rehabilitation professionals to translate functional findings into future care projections, especially for ADL and age-related mobility decline. This guidance is easiest when the patient is already receiving services, but if not, a PT/OT assessment can be requested to evaluate the patient. Asking targeted, function-based questions allows life care planners to distinguish between temporary limitations and progressive decline.

Questions for physical therapists may focus on balance scores, gait speed trends, muscle group impairments, and anticipated supervision needs. Questions for occupational therapists may address ADL safety, fatigue, effectiveness of adaptive strategies, and anticipated need for assistance with self-care and household tasks. Declining scores, slower gait, decreased balance, increased compensatory strategies,

and decreased activity tolerance often are indicators of approaching transition to higher levels of care.

Case Example:

The following case example illustrates how collaboration with physical and occupational therapists, combined with standardized assessment data, can be used to identify early indicators of decline and support accurate projection of future care needs.

Patient Profile

Ms. A is a 78-year-old female living alone in a single-story home. Her medical history is notable for hypertension and osteoarthritis, with no recent acute injuries or neurological diagnoses. She was referred for physical and occupational therapy following two reported falls in the past year, neither of which resulted in a fracture. Prior to the referral, Ms. A was independent with basic activities of daily living but reported increasing difficulty with mobility, balance, and household tasks.

Physical Therapy Evaluation Findings

On the physical therapy evaluation, Ms. A demonstrated generalized lower extremity weakness, most pronounced in the hip extensors, hip abductors, quadriceps, and ankle plantar flexors. She required the use of her upper extremities and increased time to rise from a standard-height chair and demonstrated decreased eccentric control during sitting, which can cause an uncontrolled descent.

Balance was assessed using the Tinetti Balance Assessment. Ms. A scored a 10 out of 16, indicating moderate fall risk. She demonstrated instability during turning and required increased time to regain balance following a gentle anterior nudge from the therapist.

Ms. A was assessed for gait stability. She presented with decreased step length, widened base of support, and reduced push-off bilaterally. Her score was 16 seconds, indicating increased fall risk. Gait speed measured over a 10-foot distance was approximately 2.2 feet per second, consistent with limited community ambulation and endurance.

Occupational Therapy Evaluation Findings

The occupational therapist observed decreased upper extremity strength and endurance, with grip strength measured at 32 pounds with a dynamometer. This is indicative of weakness in a 78-year-old female. Ms. A demonstrated difficulty managing clothing fasteners, opening containers, and maintaining grip while brushing her hair and teeth. Shoulder weakness limited her ability to wash her hair and retrieve items from overhead cabinets.

Functional assessment revealed that while Ms. A remained independent with basic self-care, she required increased time and frequent rest breaks. She reported feeling unsteady while showering and relied on furniture to hold onto for support during household mobility. She also demonstrated decreased tolerance for prolonged standing tasks such as meal preparation and housekeeping.

Functional Interpretation & Safety Considerations

Although Ms. A did not present with a discrete pathological diagnosis, her functional findings were consistent with predictable, age-related decline affecting balance, strength, gait, and endurance. Delayed balance reactions, reduced lower extremity strength, and diminished grip strength collectively increased her risk for future falls and loss of independence.

From a safety standpoint, Ms. A's impairments placed her at increased risk for falls during transfers, showering, stair negotiation, and community ambulation. While compensatory strategies allowed her to maintain independence presently, these strategies required increased effort and were unlikely to remain effective as decline progressed.

Life Care Planning Implications

From a nurse's life care planning perspective, Ms. A's rehabilitation findings support projections for increasing care needs over time. Recommendations include continued rehabilitation services to maintain function, installation of bathroom safety equipment, use of an assistive device for ambulation, and periodic supervision during higher-risk activities. Anticipated future needs include increased personal care assistance, particularly for bathing and household tasks, as well as ongoing fall prevention interventions.

This case illustrates how standardized physical and occupational therapy assessments provide functional and objective evidence to support life care planning projections. Early identification of functional decline allows life care planners to anticipate transitions in care needs and implement proactive, safety-focused recommendations.

Conclusion

Age-related declines in balance, strength, gait, neuromuscular reflexes, and functional performance are predictable and have significant implications for independence and safety in older adults. Integrating the physical and occupational therapy evaluation assists in predicting functional decline and how much support a patient will need. Collaboration with rehabilitation professionals allows life care planners to anticipate decline, justify recommendations, and develop plans that reflect realistic functional trajectories.

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Neuropsychology and Cognitive and Emotional Changes in the Elderly and Measurement and Documentation of Functional Deficits, and Exacerbation in Brain Injury Cases

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Keywords: Neuropsychology, Dual diagnosis, Cognitive disorders, Dementia, Brain injury, Elderly mental health, Neuropsychological assessment

NURSING DIAGNOSES TO CONSIDER
NANDA-I 2024-2026

1. Impaired Memory 2. Impaired Decision Making
3. Impaired Mood Regulation 4. Disrupted Thought Processes 5. Chronic Confusion

The mean age of older adults in the US has increased dramatically, with the 65+ population rising from 12.4% in 2004 to 18.0% in 2024 (US Census Bureau, 2024). As a result, there has been an increase in the reported cases of Major Neurocognitive Disorders (MNDs) (American Psychiatric Association, 2013). Dementia is perhaps the best known and most common MND, and there are several different types, including Alzheimer's Disease, vascular dementia, and frontotemporal dementia. The aging process presents other challenges, with older patients suffering from a wide range of other issues, such as significant psychological disturbances, a decline in physical health, an increase in chronic illness, social isolation and loneliness, life changes and stress, and medication (CDC, 2024). During a neuropsychological assessment, all of these potential issues must be considered to ensure the best results for that assessment. Coordination between neuropsychologists and life care planners ensures that clients receive the best treatment to accommodate changes related to the aging process.

People have a lot of preconceived notions of how dementia presents, with the term dementia conjuring up psychiatric dysfunction seen in some mental health disorders, such as Schizophrenia. Typically, people associate a dementia diagnosis with the way Alzheimer's Disease presents, including cognitive, emotional, personality, and other changes. Not all forms of dementia have these changes. Dementia is a general term that involves a loss of cognitive functioning (including memory, language, problem-solving/executive functioning, and other thinking abilities) that are severe enough to interfere with daily life. While Alzheimer's Disease is the most common cause of dementia/MND

(Alzheimer's Association, 2024), patients can be diagnosed with MND/dementia who have a variety of other medical problems. Patients can also be diagnosed with a Mild Neurocognitive Disorder while presenting with the same or similar symptoms as Alzheimer's Disease and other forms of dementia.

The life care planner's work is critical when persons have cognitive and psychological difficulties in older age.

Functional and Neuropsychological Assessments of Elderly Clients

The assessment and measurement of both a client's cognitive status and their psychological/psychiatric status are critical to providing proper care. As a neuropsychologist, I conduct evaluations to determine if my patient is changing in a normal fashion for age or if they are changing in an atypical fashion. I then evaluate the psychological status with good instrumentation (Table 1) and use data from the person's life to make determinations of the potential presence of a dementing process and/or psychological disorder. This provides a foundation for the life care planner to help the medical practitioners, the client, and the client's family to develop a comprehensive, customized, and evolving plan. Over time, they will be better able to manage the client's health, financial, and legal needs to ensure the highest quality of life. They can more easily assess care needs, coordinate medical and home services, navigate long-term care options, and protect assets. Life care plans can bridge gaps in care by working with elder law attorneys based on the results of the assessment.

Neuropsychological evaluation is a comprehensive process that involves the following tasks:

- A review of all medical records
- A client/patient interview
- An interview with significant others and other sources of information (e.g., work records)
- An extensive cognitive and psychological testing.

A good neuropsychologist thinks of an evaluation as an opportunity to answer specific and functional questions from the referring source (e.g., physician, attorney, caseworker, person served, or their family/guardians/powers of attorney).

Cognitive testing (Table 1) done in elderly evaluation cases should be appropriately age-based and include the following:

- Newest versions of intellectual assessment (e.g., the Wechsler Adult Intelligence Scale)
- Memory and learning (e.g., the Wechsler Memory Scale)
- Assessment of language skills, visual-perceptual skills, attention/concentration, frontal/executive function skills, and basic academics

Real-life, functional data should be obtained in extensive interviewing of spouses, children of the patient, and other sources as available and appropriate. This is critical, as the first indicators of a dementing process are often seen in life scenarios, even with cognitive testing showing no clear atypical declines. At the same time, while there are great medical advances in neuroimaging, volumetric brain assessment, biomarkers potentially indicative of a dementing process and/or other brain dysfunction, cognitive testing is also extremely sensitive to early cognitive changes, especially in cases of early dementias.

Psychological testing (Table 1) often includes the following:

- Personality assessment (e.g., the Minnesota Multiphasic Personality Inventory)
- Extensive clinical interviews
- Mood assessment (e.g., the Beck Depression Inventory)
- Anxiety status assessment (e.g., the Beck Anxiety Inventory)

Table 1 - Key Elements of Neuropsychological and Functional Assessment in the Elderly

Assessment Domain	Example Instruments	Informant Sources	Clinical Relevance
Intellectual Function	WAIS-IV	Patient	Baseline cognitive ability
Memory	Wechsler Memory Scale	Patient, Family	Early indicator of dementia
Language	Boston Naming Test	Patient	Aphasia, word-finding difficulties
Executive Function	Trail Making Test, WCST	Patient, Family	Planning, problem-solving deficits
Mood/ Pyscological Status	BDI, BAI, MMPI	Patient, Collaterals	Depression, anxiety, personality changes
Functional Status	Lawton IADL, Barthel Index	Family/ Informants	Real-life impact of cognitive changes

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II.* Psychological Corporation.

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Coordinated Efforts between Neuropsychologists and Life Care Planners

When clients have more than one medical and/or psychological/psychiatric condition, a neuropsychologist is trained to evaluate the complexity of the multiple factors that are contributing to the decline/dysfunction during daily activities. Neuropsychologists opine as to causative variables and how to address those factors. They then communicate to the life care planner specific intervention strategies to address them. These recommendations are considered critical in legal cases since the neuropsychologist is the professional who can appropriately differentiate the causation related to those multiple factors (e.g., the organic and the psychological) and the damage to both cognitive and psychological abilities. These conclusions are used in legal cases to determine causation and damages, and to allow the life care planner to proceed with the determination of life-long services, which will be necessary for that individual.

There are more typical cognitive changes that occur in aging; memory is a critical factor in determining the presence of a dementia/MND. A comprehensive neuropsychological evaluation is necessary in order to assess for what that professional knows is typical, normal aging versus a possible indicator or nontypical/nonnormal change indication.

In addition, people naturally have typical ups and downs psychologically. As a result, normal adjustment to difficult circumstances has to be considered by mental health professionals when making determinations/diagnoses of mental health conditions.

Some neuropsychologists are trained to translate testing data/scores into more practical, functional recommendations to the life care planner as specific recommendations for treatment, course of treatment (at least the initial course), and longer-term estimations of need for treatment. This allows for coordination with the life care planner as to the costs associated with the client's activities of daily living. There is no point-to-point correspondence between test scores and these determinations. The two practitioners can – and should (though some professionals are not as attuned to such collaboration) – discuss the case and help documentation by the neuropsychologist and the life care planner reflect practical recommendations.

It is particularly helpful if the evaluator in these cases has direct, connected access to rehabilitation therapies. For example, at On With Life, in Ankeny, Iowa, there is a team that works jointly and collaboratively in completing evaluations, and includes neuropsychology, psychological counseling, physical therapy, occupational therapy, and speech/language/cognition therapies. Their evaluations include neurological cases, such as traumatic brain injury (TBI), stroke/cerebrovascular accidents, and other neurological disorders, and they consider if they can rule out psychological factors. All therapy disciplines are involved in the case as requested by the referrer, and/or the rehabilitation team will make recommendations about getting these complementary evaluations done. Each of the therapists/disciplines has their own professional evaluations. While these can overlap, therapists will communicate with the other members of an evaluative team or pass on their own evaluations to recommend other disciplines. There is no need to ask for a special evaluation to be done, although this kind of collaboration is not seen nearly as often or easily outside of a rehabilitation facility that has all the disciplines available and that takes a strong team focus. Funding mechanisms can also determine whether it is possible to have the rehabilitation team involved as a whole; this can be discussed between the person making the assessment and the life care planner.

Assessing Elderly Clients with a Psychological Condition and a Brain Injury

Elderly care is a greater concern when there is an overlay of another brain injury in addition to the root cause of the changes seen prior to that injury. Neuroplasticity, also known as neural plasticity or brain plasticity, is a process that involves adaptive structural and functional changes to the brain. It is defined as the ability of the nervous system to change its activity in response to intrinsic or extrinsic stimuli by reorganizing its structure, functions, or connections after injuries, such as a stroke or TBI (National Institutes of Health, 2023).

Having a brain injury can change "the nature of the beast" in a problem that presented itself prior to the injury. There are similar and dissimilar features of the patterns of cognitive disturbances that are seen in TBI compared to other cognitive disturbances caused by dementia/MND. In addition, if the person carried a diagnosis of a psychiatric condition before a brain injury, that person can still present with symptoms of that premorbid (prior to injury) condition. However, it can also present in an odd, skewed, or dissimilar fashion.

It's important to keep in mind that there are many times in which inappropriate diagnoses are given to persons having brain damage/dysfunction due to their presentation of symptoms that look superficially like another condition/diagnosis. For example, a medical professional could diagnose schizophrenia in a person with brain dysfunction that causes confusion because it looks like delusions, or they could diagnose manic depression in a person with brain dysfunction that causes notable mood swings. The symptoms are similar, leading to the misdiagnosis. This can be mediated by having a neuropsychologist involved in the diagnostic conceptualizations of the individual with brain damage or

dysfunction. The neuropsychologist helps determine the primacy of a mental health diagnosis, including taking the patient's history into account, versus presentation post-brain injury/dysfunction that "mimics" the signs/symptoms of a primary, specific mental health diagnosis.

Case Study

I partnered with a life care planner to assist an elderly woman in a brain injury rehabilitation center/agency who had had a severe Feeding and Eating Disorder (ED) (DSM-5) – Bulimia Nervosa. She had received professional (both outpatient and inpatient) treatment in her history, with less-than-optimal treatment success into adulthood. She sustained a brain injury related to diabetic coma. Her ED symptoms returned but presented differently due to confusion, memory, and cognitive dysfunction associated with her brain injury. In addition, as her cognitive status improved over time, she benefited from alterations to treatment approaches, which changed the nature of the future service needs.

In collaboration with the life care planner on this case, we engaged in detailed discussions regarding the practical aspects of the patient's care following post-acute rehabilitation provided by the agency. Together, we evaluated potential sources of ongoing treatment, associated costs, anticipated durations of care, and the scope of outpatient services, including professional counseling. We jointly considered whether these services would be most appropriately delivered by brain injury rehabilitation specialists, ED professionals, or a combination of both. Through this collaborative process, we developed an integrated care approach that leveraged the expertise of both disciplines, resulting in a more effective and comprehensive plan for the patient.

Best Practices for Life Care Planners

Life care planners are encouraged to collaborate with neuropsychologists or other healthcare professionals who value and actively engage in a team-based approach to care. Effective collaboration provides opportunities to ask questions, clarify the goals and scope of evaluations, and translate assessment findings into practical, real-world recommendations that support comprehensive life care planning. While not always the standard practice, it is beneficial for neuropsychologists to complete their reports within two weeks of seeing a client, as life care planners rely on timely and accurate information. Communicate clearly and assertively with the neuropsychologist about your specific needs to ensure you can provide the highest quality service to your clients.

The Benefits of Collaborating with Neuropsychologists for Elder Care

Life care planners should consult with a neuropsychologist (or other health care practitioner) who is not just available with a phone call, but who enjoys, appreciates, and understands the importance of collaborative care. This collaboration allows participants to ask questions, clarify the intent of the evaluation and questions to be answered, and to translate testing data into real-life recommendations, which helps the life care planner. While this may sound obvious, neuropsychologists should get their reports done within two weeks of seeing a client; unfortunately, this is not standard practice. The life care planner and others are awaiting those reports to finish their work. When needed, it is fine to be assertive with the neuropsychologist who is involved in the case to ensure you have what you need to develop a more comprehensive life care plan for the complex needs of an elderly client.

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NAVIGATING THE COMPLEXITIES OF ELDER CARE ADVOCACY:

Insights for Nurse Life Care Planners and Case Managers

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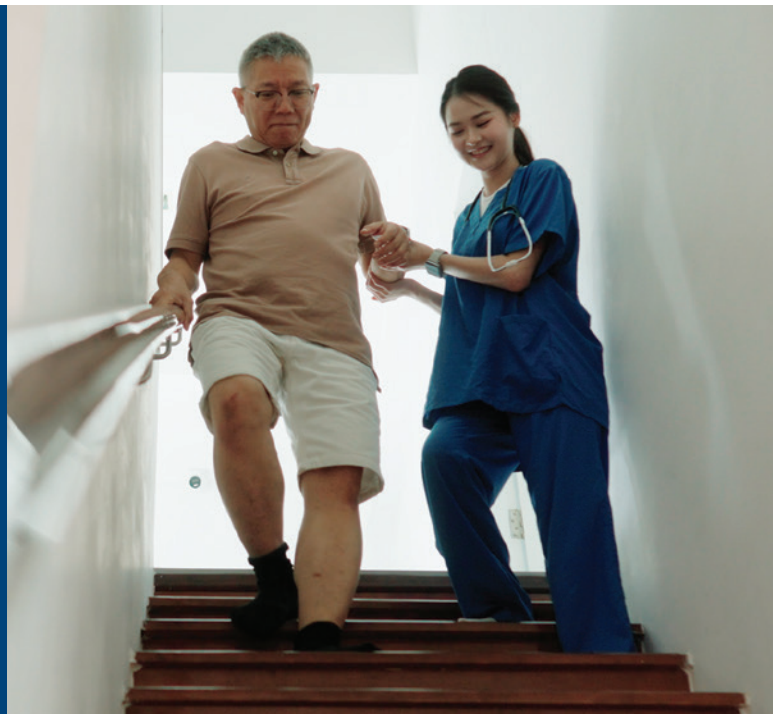

Keywords: Advocacy, Exploitation, Long-term planning, Dementia care, Elder care

NURSING DIAGNOSES TO CONSIDER
NANDA-I 2024-2026

1. Powerlessness 2. Impaired Decision Making 3. Ineffective Coping 4. Social Isolation 5. Elder Frailty Syndrome

Elder care often extends beyond medical management to include legal, financial, and social challenges. Gaps in preparation in these areas can lead to severe consequences, including financial exploitation or inadequate end-of-life care. Elder financial exploitation is a growing crisis. In 2024, adults aged 60 and older reported losses of $2.4 billion to fraud—a sharp rise from $600 million in 2020—driven largely by high-value scams such as romance and investment frauds, many originating on social media platforms (Federal Trade Commission, 2025).

Nursing home care remains prohibitively expensive. National averages in 2026 are approximately $119,340 annually for a shared room and $136,948 for a private room. These costs highlight the importance of strategic resource planning, such as qualifying for Medicaid (Medicaid Planning Assistance, 2026a).

The Role of Patient Advocates

Professional patient advocates bridge these gaps by assisting with advanced directives, Medicaid applications, care coordination, and scam prevention. This article uses case studies to illustrate interconnected challenges and demonstrates how life care planners and case managers can collaborate with advocates or adopt similar strategies to enhance client outcomes.

A patient advocate is a professional who protects, represents, and guides individuals and families through complex healthcare, insurance, and government benefit systems. Patient advocates do not provide medical care or replace physicians or nurses. Instead, they serve as healthcare strategists, educators, and systems experts. Their role often includes the following tasks:

- Help clients understand diagnoses and treatment options
- Prepare for medical appointments and ask informed questions
- Coordinate care between providers
- Navigate hospitalizations and discharge planning
- Review medical bills for accuracy or negotiation
- File insurance appeals and grievances
- Apply for Medicaid, VA benefits, and Social Security Disability.

Some patient advocates also plan for long-term care funding, make informed end-of-life and advance directive decisions, provide fiduciary oversight when needed, and support families managing dementia.

Patient advocacy is especially critical in high-complexity cases involving aging, cognitive impairment, catastrophic illness, or long-term care placement. Advocates serve as translators of complex medical and legal terminology. They work as

problem-solvers when systems fail and act as a check against financial and administrative errors. Families and caregivers also need a lot of support and guidance working through emotionally challenging decisions. Advocates must remain neutral, with loyalty solely to the client. This role becomes vital when families are overwhelmed, geographically distant, or dealing with dementia, brain injury, or end-of-life care.

Managing Clients and Their Needs

Patient advocacy focuses on key themes that address most client needs:

- End-of-life planning
- Financial navigation and protection
- Transitions to supported living environments
- Prevention of exploitation.

Most clients are referred through word-of-mouth, elder care services, hospital discharge planners, and senior care networks.

- A word-of mouth referral might be someone at church who is struggling to provide care for a spouse or elderly adult. They reach out because they are struggling, and they do not know what they need or where to begin. They just know they are overwhelmed.
- For elder care services referrals, they might reach out because they are concerned about the person for whom they provide care but feel they need additional services that they don't provide.
- For hospital discharge, they will reach out when a patient is ready for discharge, but they are unsafe to return home on their own and they aren't eligible for government assistance due to being above resource to qualify (i.e., they own two cars).
- For senior care networks, someone attending a networking event might reach out to provide services because it would be a conflict of interest for them to help since they are employees or owners of a home health agency, nursing home, etc. They want to provide the client with help collecting documents necessary to apply for Medicaid benefits or serving as a medical or durable power of attorney and need a disinterested third party.

Many patient advocates offer a complimentary initial consultation to assess whether they can assist a family. This no-cost call helps identify the specific needs and determine the best path forward.

The patient advocacy practice of these authors goes a step further: even when unable to take on a case, secondary resources or helpful information are provided at no charge. As a private-pay service, there are times families who lack financial means to engage in services are encountered. In such situations, advocates readily refer callers to appropriate local resources. For example, when an out-of-state family contacts the advocacy practice seeking housing assistance for an aging parent who lives locally, the team will connect them with community organizations and support services that can help at little or no cost.

The only people this advocacy practice typically declines are those involving persons seeking pain management assistance after having been discharged from care due to misuse of medications or other issues they themselves created.

Advocates assist clients and families in taking care of tasks and documentation that could be forgotten while trying to take care of the client. Advance directives, living wills, powers of attorney, and burial plans are essential but often overlooked until a crisis arises. Without them, families face a range of compounding issues, such as rushed decisions and conflicts, or even court intervention. Proactive planning honors the individual's wishes and reduces caregiver burden. To provide the best possible care, advocates and life care planners conduct a comprehensive assessment of both the client's condition and the care provided by their caregivers. During evaluations, life care planners can assess preparedness, recommend state-specific directive forms, and suggest consultations with elder law attorneys as part of the overall life care planning process.

The following are some of the available resources for patient advocates and caregivers to older adults.

ELDER CARE RESOURCES

RESOURCES	WEBSITE	DESCRIPTION
ORGANIZATIONS		
AARP	https://www.aarp.org	Nonprofit organization that provides resources for retirees and people over 50 years old. Patient advocacy services through Solace include assistance locating specialists, scheduling appointments, and negotiating bills.

ELDER CARE RESOURCES

RESOURCES	WEBSITE	DESCRIPTION
ORGANIZATIONS		
Alliance of Professional Health Advocates	https://aphadvocates.org/	Prominent professional organization for patient advocates which includes a locator service for advocates in the US.
Greater National Advocates	https://gnanow.org	National network of patient advocates who specialize in different areas of need. Advocates in this network include physicians, nurses, aging life care planners, social workers, case managers, board certified patient advocates and more.
National Council on Aging	https://www.ncoa.org	Provides resources and tools for older adults and caregivers.
Office for Victims of Crime / Office of Justice Programs	https://ovc.ojp.gov/program/elder-fraud-abuse/overview	An office within the US Department of Justice that provides services and resources to crime victims, including elder fraud and abuse. They have a national hotline for reporting elder abuse and fraud.
CERTIFICATIONS		
Certified Alzheimer's Caregiver	https://ncbac.net/cac-certification	National Certification Board for Alzheimer Care offers a certification program that promotes the public good by providing credentialing and registry services for those who care for people with Alzheimer's disease and related disorders.
Certified Brain Injury Specialist	https://biausa.org/professionals/academy-of-certified-brain-injury-specialists/certified-brain-injury-specialist	Certified Brain Injury Specialists (CBIS) are recognized in the field of brain injury for demonstrated professional experience, knowledge, and skillset to meet individuals' brain injury rehabilitation and health needs by practice setting
Certified Dementia Practitioner	https://www.nccdp.org/cdp/	Alzheimer's Disease and Dementia training certification by the National Council or Certified Dementia Practitioners representing excellence in dementia care.

ELDER CARE RESOURCES

RESOURCES	WEBSITE	DESCRIPTION
CERTIFICATIONS		
Patient Advocate Certification Board	https://www.pacboard.org/	BCPA is a credential open to those serving patients and their families who need assistance with some portion of their journey through the healthcare system. It includes a list of current certificants.
RESOURCES AND PROGRAMS		
Hwalek-Sengstock Elder Abuse Screening Test	https://familymedicine.medicine.uiowa.edu/sites/familymedicine.medicine.uiowa.edu/files/2024-11/HS_EAST.pdf	A screening test for elders helpful in identifying those at high risk for abuse.
Money Smart for Older Adults Program	https://www.fdic.gov/consumer-resource-center/money-smart-older-adults	This resource is provided by the FDIC and includes information for older clients and caregivers to minimize the risk of financial exploitation.
Scams Targeting Older Adults	https://www.fdic.gov/consumer-resource-center/2025-07/scams-targeting-older-adults	This FDIC provided resource lists current scans targeting older adults and provides suggestions for minimizing risk.

Handling the Cost of Long-term Care

Long-term care costs often exceed personal resources, making Medicaid eligibility essential for many clients. In 2026, most states set the income limit for long-term care Medicaid at approximately $2,982 per month for a single applicant (300% of the Federal Benefit Rate). Asset limits are typically $2,000 for countable resources, though certain items—such as a home under specific conditions—are exempt (Medicaid Planning Assistance, 2026b).

There are numerous resources and programs to help with the cost of elder care. Advocates and life care planners help connect clients and their care givers with available programs, including the following:

- Home and community-based services (HCBS) waivers
- Assisted living facility waivers (with limited availability)
- Nursing home Medicaid.

After reaching out to these programs to start enrollment, advocates help with completing tasks required to join them. This includes things like documentation, asset liquidation, and spend-down strategies, including Medicaid-protected annuities for non-institutionalized spouses. Eligible veterans also have additional financial support through VA Aid and Attendance benefits.

Regarding care coordination and transitions in care, patient advocates can reign supreme. Finding suitable care—whether in-home, assisted living, or long-term care—requires the advocate be knowledgeable about the types of care available and the staffing available. They have to address environmental concerns and other issues that could arise from an inadequate care facility. Patient advocates often provide coordination of appointments, rehabilitation (e.g., post-fall or post-surgery), medication management (e.g., securing programmable dispensers), and daily supports (e.g., homemaker services, emergency call buttons). Transitions from home to facilities demand advocacy to prevent isolation or falls and maintain dignity.

Common Scams and Their Risks

Elder scams, particularly those of a romantic nature, exploit loneliness and trust, often draining life savings. Social media has been ripe with scams, especially targeting seniors. There

are several prevalent types of elder scams, but they take a few similar approaches to financially drain the target. The following are some of the most common signs of an elder financial scam:

- Isolation from family
- Sudden or unexplained financial changes in account activity
- Unpaid bills or decline in standard of living
- Abrupt changes to legal or financial documents
- Missing cash, jewelry, or other items.

While these are the most frequent signs, there are some less obvious and more insidious signs including new and overly involved "friends", caregivers or companions, pressure or urgency about gift cards, wire transfers, or other hard to trace financial transfers.

Romance scams, also known as sweetheart scams, frequently start on dating apps, social medial, or text/email and evolve quickly. Nearly 1 in 10 adults age 50 and older (about 11 million Americans) have experienced an online romantic connection that led to a request for money or cryptocurrency investment, with adults ages 50 to 64 at more than double the risk compared to those 65 and older (AARP Research, 2026). Common signs include love bombing, avoidance of in-person meetings or video calls, pushing to move off platform quickly, inconsistent stories, and requests for money or financial help.

Adult Protective Services and police involvement may follow, but prevention through fiduciary oversight and education is key. Most senior adults, especially those over age 75, do not have persons or a third party to share information with that might help identify a potential scam.

Case 1: Comprehensive Advocacy in Dementia Care

An elderly couple connected through a local church sought help when the wife showed signs of declining health, including confusion, memory lapses, and difficulty with daily tasks. The husband became overwhelmed managing her personal health concerns. The patient advocate listened to his concerns about symptoms such as fluctuating alertness and visual hallucinations. She then assisted in securing an appointment with a neurological expert with a special interest in dementias. She attended the appointment with the couple at which time the diagnosis of Lewy body dementia was made. This is a condition affecting an estimated 1.4 million Americans and accounting for 4 to 16% of dementia cases in clinical settings (Lewy Body Dementia Association, n.d.).

Advocacy efforts included coordinating transportation to appointments, attending sessions to ensure the husband's questions about treatment options were addressed, and implementing automatic pill dispensers to reduce medication errors. Education on health management apps and how to access their medical records was provided, along with supported remote monitoring. Daily support involved arranging meal services and accompanying the couple to physical therapy.

As the condition progressed, adult day-care, in-home care, and respite care were introduced to prevent caregiver burnout. As this took a financial toll on their savings, the patient advocate assisted in applying for a Medicaid Waiver for home and community-based services. This holistic approach delayed institutionalization and improved their quality of life, highlighting the value of early intervention, care coordination, and technology education to maintain independence.

Case 2: Financial Exploitation and Recovery

An older woman with vision impairment experienced multiple falls requiring surgical intervention. She had no biological children, and the referral came from her stepdaughter, who had been advised it was no longer safe for her to remain alone at home. During post-rehabilitation discussions regarding fees, moving companies, etc., her bank account was checked, and it was discovered that she had been victimized by a romance scam originating on Facebook. The male perpetrator gained her trust over several months. He indicated he was working at the Pentagon on a special assignment in the Middle East and needed phone cards, gift cards, and other monetary gifts sent to him. This eventually led to his obtaining access to financial accounts and her losses exceeded $350k from her retirement savings. With limited family involvement, referral to advocacy support occurred after concerns about isolation were noted.

Interventions included immediate fiduciary measures (such as redirecting mail and freezing accounts), filing reports with law enforcement and Adult Protective Services, and local law enforcement and pursuing partial recovery through financial institutions. Coordination ensured a safe transition to assisted living with accessibility accommodations. Ongoing assistance involved managing long-term care insurance documentation. The case revealed common red flags, including social isolation and resistance to assistance, and demonstrated the advocate's role in financial recovery, crisis response, and secure transitions. Police became involved, and the perpetrator was tracked to Nigeria but was ultimately located in New York. Unfortunately, they never recovered any of her funds.

Case 3: Asset Protection and End-of-Life Decline

Mr. and Mrs. S, a retired professional couple, without children, faced progressive cognitive decline for the wife with an Alzheimer's diagnosis. Initial efforts by patient advocacy focused on asset protection to facilitate future eligibility for public benefits for Mrs. S. As needs escalated, in-home care was arranged for her, and after a rapid decline, this was followed by placement in specialized long-term memory

care. Mr. S was moved to an assisted living facility where he would have meals and housekeeping services as well as an emergency call button. Following Mrs. S's passing, the surviving husband experienced rapid health deterioration, including behavioral changes, respiratory needs, and medication management difficulties. He lost his will to live.

Advocacy supported the implementation of safety devices such as medication dispensers, hiring of round-the-clock assistance, facilitation of hospice enrollment, and completion of estate planning elements such as charitable donation of his vehicle. A subsequent fall required prompt emergency coordination. Upon his passing, patient advocacy was charged with liquidating their assets and arranging for the proceeds to go to the charitable causes he had outlined. This case illustrates the emotional impact of loss, the importance of escalating care levels, and the benefits of proactive financial and estate strategies.

Case 4: Medicaid Application and Spend-Down

A 76-year-old female found herself in a prolonged spend-down process utilizing her proceeds from asset sales for legal fees, relocations in living environment (including an eventual move to memory care), and ongoing services amid neurodegenerative progression. The case was referred by staff at the residential facility after recognizing that if she continued to pay private pay, she would not have the funds to pay for memory care when needed. They were stuck without her being able to pay the facility, forcing another move. Challenges involved managing income streams and high private-pay facility costs. Guidance focused on compliant asset liquidation, benefit applications, and eligibility achievement.

The process highlighted complexities in pathways to coverage and the necessity of sustained support during spend-down periods, emphasizing collaborative monitoring of compliance.

Collaborating with Patient Advocates

Patient advocates often connect through community networks, healthcare settings, or senior events and manage non-clinical tasks such as coordinating services, overseeing correspondence, fulfilling fiduciary responsibilities, and navigating crises. Life care planners can refer clients or collaborate on assessments to enhance interdisciplinary care.

It is important for life care planners to assess early using checklists for legal documents, scam risks, and care preferences during initial evaluations, particularly in the elderly and isolated. The National Institutes of Health has one focused on preparing legal, financial, and health related documents. The Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) is a 15-item screening tool helped to identify potential elder abuse. Life care planners and patient advocates may develop their own checklists as part of their initial assessment. When noted, consider securing a patient advocate to then include financial snapshots and review periods for asset evaluation. When assets are limited, certain protective strategies may be less suitable; consultation with qualified professionals can guide liquidation into compliant structures timed appropriately before care needs arise.

It is important that patient advocates educate clients on red flags for exploitation, such as unsolicited financial requests via social media, and encourage reporting to appropriate authorities. Resources include educational materials readily accessible from the FDIC (2025), National Council on Aging (2024), AARP, Office for Victims of Crime (2023), and FTC.

Patient advocates can facilitate access to resources by guiding applications for public benefits and recommending supportive tools like medication dispensers, emergency alerts, and respite services. Life care planners and case managers should promote collaboration with patient advocates for comprehensive planning and support expanded program availability. Patient advocates can prevent crises through proactive discussions on end-of-life preferences and financial reviews to address vulnerabilities and ensure care continuity.

Patient advocates vary in training and scope. When selecting an advocate, consider board certification through nationally recognized bodies, such as the Patient Advocate Certification Board. Certification demonstrates competency, ethical standards, and continuing education. Relevant professional memberships reflect commitment to standards and ongoing learning. Two prominent organizations are the Alliance of Professional Health Advocates and National Association of Healthcare Advocacy Consultants. Membership in these professional organizations reflects commitment to professional standards and ongoing education. The National Association of Healthcare Advocacy Consultants emphasizes a code of ethics and best practices for the field (National Association of Healthcare Advocacy Consultants, n.d.).

Costs for patient advocacy services vary depending on the advocate's level of expertise, years of experience, and the type of services required. Some advocates charge by the hour, while others charge a flat fee per specific task. For example, an advocate might charge a flat fee to tour three nursing homes and provide a recommendation to the family, or to complete a Medicaid application. The same advocate may bill hourly for services such as welfare checks or fiduciary responsibilities.

Specialized certifications may be valuable for specific needs, such as those related to cognitive impairment or neurological conditions. Some non-nurse related certifications of benefit are the Certified Brain Injury Specialist (CBIS), Certified Dementia Practitioner (CDP), and Certified Alzheimer's Caregiver. Professionals working with dementia or brain injury rehabilitation may pursue the Certified Brain Injury Specialist credential to demonstrate specialized knowledge (Brain Injury Association of America, n.d.). The Certified Dementia

Practitioner certification supports frontline staff in providing compassionate dementia care (National Council of Certified Dementia Practitioners, n.d.). Patient advocates can earn the Certified Alzheimer Caregiver designation to validate their understanding of Alzheimer's-specific needs (National Certification Board for Alzheimer & Aging Care, n.d.).

Experience in government and insurance systems—including Medicaid long-term care eligibility, veterans' benefits, Social Security Disability, and appeals—is often essential. Ethical boundaries should include a clearly defined scope of practice, avoidance of unlicensed medical or legal activities, disclosure of conflicts, and exclusive loyalty to the client.

Conclusion

Elder care demands more than medical coordination alone. Professional patient advocates serve as systems experts, strategists, and protectors, particularly in complex situations involving aging, disability, catastrophic illness, or long-term care planning. Vigilance against financial, legal, and social vulnerabilities is essential. By understanding these themes through real cases, life care planners and case managers can better support aging clients, prevent exploitation, and ensure dignified care transitions. Interdisciplinary partnerships offer a path to more resilient outcomes in an evolving landscape of elder needs.

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LEGAL NURSE VOICE:
Insights from a Legal Nurse Consultant

Beyond the Event:
Patterns and Vulnerabilities in Elder Care Cases

By: Sarah O' Connor BSN, RN, GERO-BC, WCC, CDP

Keywords: Long-term care, Pressure Injuries, Falls

NURSING DIAGNOSES TO CONSIDER
NANDA-I 2024-2026

1. Risk for Falls to Impaired Mobility and Cognitive Impairment 2. Impaired Skin Integrity Related to Pressure, Friction, and Shear 3. Risk for Elopement Attempt Related to Cognitive Impairment and Wandering Behaviors

Adverse events in long-term care often arise at the intersection of frailty, care delivery, and documentation. In litigation review, certain clinical vulnerabilities consistently appear in mobility, skin integrity, cognition, and individualized care planning. These issues most commonly present as falls, pressure injuries, elopement, and failures in care plan development, implementation, or reevaluation.

Acute hospital settings and long-term care environments both require ongoing assessment and adjustment of care. In long-term care, however, residents are managed over extended periods with evolving needs. The focus shifts from single event outcomes to the continuity of interventions, monitoring, and reassessment over time. Within this longitudinal framework, clinical processes (such as risk identification, care planning, and intervention) function as part of a recurring cycle that supports maintenance of function and quality of life. This approach aligns with regulatory expectations that can be continuously assessed, implemented, and modified in response to changing resident needs (Centers for Medicare & Medicaid Services, 2024).

As the aging population grows, the complexity of long-term care continues to increase. Residents present with multiple, interrelated vulnerabilities that evolve. These vulnerabilities rarely occur in isolation. Instead, they create overlapping care needs that require ongoing assessment, coordination, and adjustment of individualized care plan interventions. Documentation expectations mirror the demands of this environment and require consistency in how care is delivered, recorded, communicated, and evaluated. This dynamic is central to the review, requiring evaluation of both individual incidents and the coordination and adaptation of care in response to changes in the resident's condition, including subtle changes that may signal evolving risk. Over extended periods, subtle changes in condition may be difficult to recognize. When clinical processes are consistently followed, however, these changes serve as important triggers for reassessment and adjustment of care.

Falls

Falls are among the most frequently reviewed events in elder care and often occur in resident rooms, bathrooms, or during transfers. The review process examines a variety of risk factors, such as supervision needs, environmental conditions, cognition and mentation, functional ability, continence, medications, and underlying medical conditions. The review includes admission

fall risk assessment, then ongoing and post-fall reassessment in response to changes in condition or subsequent falls. It also includes corresponding care plan interventions. Supporting documentation, particularly therapy notes, provides important context regarding functional status and mobility. Each fall should prompt updates to the care plan to reflect evolving risk and the need for modified interventions.

The critical question is whether risks were identified, consistently addressed, and effectively managed. Falls often reflect cumulative risk rather than a single precipitating factor.

For example, a resident with impaired judgment may be identified as a high fall risk yet repeatedly attempts to ambulate independently despite supervision and safety measures in place. These scenarios often involve underlying mobility impairments, including decreased strength, balance, or coordination, along with factors such as continence needs and visual impairment.

In these cases, the focus is on whether interventions like increased supervision, environmental modifications, appropriate use of assistive devices, and therapy services were consistently implemented and adjusted as risk status evolved. What matters is whether the care plan accurately reflects the resident's needs. This expectation is grounded in regulatory standards for comprehensive assessment and ongoing evaluation of functional status and changes in condition.

Pressure Injuries

Just as mobility concerns can contribute to falls, limitations in movement can also lead to skin breakdown. Skin breakdown most commonly occurs over bony prominences such as the sacrum, coccyx, heels, ankles, and hips. Pressure injuries require preventive care such as addressing offloading, specialized support surfaces, mobility, nutrition, dehydration, and continence. They also require consistent skin and wound assessment, along with accurate documentation to support early identification. Ongoing evaluation focuses on wound changes and the development of new areas of skin breakdown or areas at risk.

The critical question is whether risks for skin breakdown were identified, consistently addressed, and effectively managed.

These cases hinge on the timely identification of risk for skin breakdown, implementation of appropriate interventions, and ongoing evaluation to ensure care remains aligned with the resident's needs. Evaluation includes determining whether documentation reflects wound progression, stability, or deterioration. The review considers factors such as risk assessments (including the Braden Scale), documented wound status with routine measurements, and response to treatment. Lack of improvement or evidence of deterioration indicates the need for reassessment and modification of the treatment plan. Care is guided by regulatory expectations for comprehensive assessment, care planning, and ongoing evaluation of skin integrity and associated risk factors.

Breakdowns in care may include inconsistent repositioning, gaps in documentation, inaccurate or incomplete skin assessments, failure to identify and document risk factors, and delayed recognition of early skin changes.

Cognitive Vulnerabilities

Cognitive vulnerabilities present unique challenges across elder care settings, particularly in assisted living and memory care environments, where they contribute to risks such as wandering and elopement. Elopement cases involve the review of factors such as the resident's level of cognitive impairment, supervision plans, timeliness of staff response, and location.

The critical question is not simply whether a resident exited the facility, but whether individualized risk assessments and preventive measures were adequate and consistently implemented. This includes whether staff had appropriate education and training. Even when residents have similar cognitive impairments, each individual has unique needs that require proactive management and ongoing adjustment. These needs are supported by person-centered care plans with appropriate interventions to prevent or de-escalate unsafe and challenging behaviors.

Changes in cognition, behavior, and functional ability serve as triggers for reassessment and care plan revision. Failure to recognize and respond to these changes reflects a breakdown in care delivery. Care is guided by regulatory expectations for assessment, supervision, and individualized care planning for residents with cognitive impairment.

Breakdowns in care may include wandering, attempts to exit secured areas, or escalating behaviors that were not consistently recognized or addressed.

Care Planning

Across these vulnerabilities, a common thread is the degree to which care plans are developed, implemented, modified, and consistently followed. The focus is on alignment from the assessment through the development of the care plan to the delivery of care. This alignment is shaped by nursing judgment, interdisciplinary collaboration, and regulatory standards that guide expectations for assessment, documentation, and clinical oversight in long-term care.

Effective care delivery depends on coordination across disciplines, with each contributing to the identification, communication, and management of risk. Discrepancies between planned and delivered care often form the basis of legal review, revealing whether resident needs were

accurately identified and whether interventions were implemented, evaluated, and adjusted in response to changes in condition.

In long-term care, this process is supported by a team-based approach that includes social services, dietary, therapy, and activities, with involvement of the resident and family.

Ultimately, the common denominator across these categories is not the adverse event itself, but the consistency, continuity, and quality of clinical reasoning and documentation. Even when standards are generally implemented, gaps can still emerge and require careful review. The most defensible cases reflect consistent, documented care that adheres to standards and adapts in real time to the resident's condition.

Conclusion

For legal nurse consultants, value lies in recognizing patterns and inconsistencies in care across the course of review. This work requires evaluating how clinical vulnerabilities intersect with care delivery and documentation. The focus is on whether risks were identified, interventions implemented, and care consistently reassessed and modified. Analysis highlights gaps, inconsistencies, and missed opportunities that reflect breakdowns in care. These findings form the basis for determining whether the standard of care was met and whether care delivery aligns with accepted clinical practice.

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COMMUNICATION AND CONTINUITY OF CARE BETWEEN CAREGIVERS:
Practical Strategies and Tools

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Keywords: Coordination of care, Caregiver tools, App Tools

NURSING DIAGNOSES TO CONSIDER
NANDA-I 2024-2026

1. Readiness for Enhanced Health Knowledge 2. Readiness for Enhanced Coping 3. Impaired Verbal Communication 4. Readiness for Enhanced Family Processes 5. Risk for Ineffective Health Self-management

Effective communication is the backbone of quality elder care. Whether you're coordinating with healthcare providers, family members, or support services, ensuring everyone has the right information at the right time is crucial for the well-being of those receiving care. One of the most significant issues with long-term care is ensuring all parties have the current information on the elder adult's care. Without it, unnecessary difficulties or insufficient care may occur.

This article discusses elder clients who often need increased care and services as they age. This information is relevant for any individual, at any age, whose care involves multiple parties. As the number of participants increases, effective coordination and communication regarding changes becomes essential.

A Significant Barrier to Proper Care

According to the AARP 2026 Caregiving Report (AARP, 2023), a persistent and significant challenge in elder care is inadequate communication among caregivers and between caregivers and healthcare providers. The report highlights issues such as inconsistent or incomplete information from providers, poor communication among multiple caregivers—both family and paid staff—and a lack of inclusion in hospital discharge or care transition processes. This research underscores that communication breakdowns are a central part of broader care coordination challenges.

While there are some promising solutions in progress for federal and state policies and practices (AARP, 2023), these often take a long time to get through all of the red tape. Then it can take a while for them to be fully implemented. In the meantime, caregivers continue to face challenges to providing proper care. Life care planners are in a position to help during this period, giving caregivers options in how to best coordinate with each other, especially for families and friends.

Beyond medical care, caregiving often involves relying on a network of people and services to manage daily needs. For example, your essential contacts might include a heating and cooling company, plumber, primary care provider, specialists, hair stylist, dentist, pet sitter, mowing or snow removal services, and neighbors. This isn't something that will be covered by the solutions currently being considered, but it is just as important for caregivers to have this information should something happen that requires attention.

Mapping a Client's Network

To ensure that all caregivers have easy access to contacts, information needs to be recorded to be readily available. Since each person's network is unique, the first place to start is with mapping out each of their contacts to ensure seamless support.

Use the following as a guide on how to start documenting all of the potential contacts that a client may need:

- List every service provider and contact your care recipient uses, including medical professionals, household services, and social contacts.
- Research and verify the following details about each of those contacts:
  - Phone numbers
  - Physical address
  - Email address
  - Emergency contact number (if necessary).
- Update this list regularly as needs and relationships change.

When managing care for someone else—whether a special needs child, older parent or friend, or adorable pet—it's essential to know their support network. Ask questions like the following:

- Who does Aunt Susie call to shovel her walk?
- Who does Mom contact for supplemental oxygen?
- Where does Uncle Chris get his medications?
- What vet does neighbor Vicky use for her dog's prescriptions?

Understanding these connections ensures continuity and prevents gaps in care. Initially, a care giver can start by mapping the information in a journal or Word document, but eventually, they'll want to make it more easily accessible.

To streamline the process of mapping all of the information, divide it into different sections based on the kind of care the contact provides. The following are a few suggestions:

- Physicians
- Specialists
- Pharmacies
- Vet care
- House care (plumbers, electricians, landscapers, and other people who provide care of the client's home)
- Transportation

Add categories that make sense for your loved one or client. This will make it much easier to share information with other caregivers.

Sharing the Responsibilities of Care

Care responsibilities often shift between family members and friends. For example, if you are Mom's primary caregiver and she spends six weeks visiting your sibling, it's vital to transfer all relevant details accurately.

The contacts that your siblings should have relate to all of your Mom's medical needs. Sharing medical updates, medication lists, and provider contacts ensures that care remains consistent and uninterrupted during her stay with them. Before she leaves, complete the following tasks:

- Make a checklist of essential information to pass along.
- Use collaborative tools to update and share information.
- Arrange regular check-ins to address questions and new concerns.

This not only ensures your sibling has all of the necessary information in case of an emergency, it gives all of you peace of mind to enjoy the duration of her time away from home.

The National Institute on Aging (2023) provides a lot of free worksheets to help people plan for the care of an older client. One of the worksheets focuses on coordinating caregiving responsibilities, which can be helpful for life care planners who are trying to help family and friends coordinate care.

Tools for Managing Elder Care Information

Many families rely on text and email chains, notebooks, and sticky notes to exchange information. While these methods are familiar, they often result in miscommunication, outdated records, and frustration from not having accurate details when needed. There is also the risk of paper copies getting lost and emails being deleted. Traditional methods of tracking information are no longer the best way of maintaining information, especially when it concerns the care

of a loved one. Fortunately, there are a number of digital options that will help caregivers coordinate care with both the older adult and other caregivers.

Patient care portals like MyChart offer access to medical results, but lack interoperability across different providers and systems, making information-sharing difficult and sometimes leading to redundant tests or missed updates. This is a familiar problem to medical professionals since it was a problem in the early days of digitizing data in hospitals, clinics, and private practices.

There are apps that focus on one element of care, such as the apps Medisafe and MyMeds, which provide tracking for medication. Medisafe is free and helps with things like tracking medication doses, alarms to serve as reminders, and interaction warnings for medications. MyMeds helps caregivers work with pharmacists for better care. There are also GPS tracking devices with corresponding apps to track a person's location and conditions. The problem is that these apps are fairly specialized, so they don't provide an easy way of coordinating care between different caregivers. However, they can be part of the list of contacts, tools, and information shared between caregivers so that everyone is using the same apps for these particular aspects of tending to the older adult.

There are also scheduling apps, such as Caregiving Village and Lotsa Helping Hands, to help coordinate meals and care for a loved one. These apps include ways to track and manage an elderly client's dietary needs, along with other features, like the following:

- A calendar for tracing tasks beyond meals, such as rides to appointments
- A message area for sending short chats to support the person (this is helpful as many older adults have less social interaction and are more likely to express feeling lonely)
- An area to upload images that can be shared with other caregivers or the client
- A wellness journal for tracking how the client is doing

These apps act as a method of coordinating certain aspects of care and of helping the older client to feel supported, even when they are alone.

Apps like the Caregiver's Toolkit are designed as a centralized, cloud-based resource for managing all aspects of caregiving. Features and benefits of these apps include the following:

- **Uploading Medical Documents:** Store and access prescriptions, lab results, hospital discharge papers, and insurance information securely.
- **Setting Appointment Reminders:** Schedule medical visits, therapy sessions, and check-ups, with notifications for upcoming events.
- **Tracking Medication Changes:** Log new prescriptions, dosage adjustments, and discontinued medications in real time, ensuring everyone is informed.
- **Sharing Access Securely:** Invite trusted family members, caregivers, or healthcare providers to view or update information as needed, with customizable permissions.
- **Organizing Essential Contacts:** Keep a master list of all providers, service contacts, and emergency numbers.
- **Notes and Updates:** Add ongoing observations, updates, or instructions for other caregivers and family members.
- **Mobile Accessibility:** Access the toolkit via smartphone, tablet, or computer, enabling real-time updates from anywhere.

The following are a few tips to get started:

- **List Essential Contacts:** Start by compiling names, phone numbers, and email addresses for all providers and service contacts.
- **Organize Information:** Upload medical documents, create medication lists, and input appointment schedules.
- **Set Up Regular Check-Ins:** Schedule weekly or bi-weekly calls or updates with other caregivers to review changes or concerns.
- **Learn and Use the App Features:** Take advantage of reminders, secure sharing, and note-taking for seamless collaboration.
- **Keep Information Updated:** Make it a habit to review and revise the toolkit as medications, providers, or care routines change.
- **Ask for Help:** Don't hesitate to invite trusted individuals to assist with updates, or to reach out to healthcare providers for clarification.

There are many apps for helping take care of elderly clients (Where You Live Matters, 2020). Each app has a different pricing model—some require monthly or annual subscriptions, while others are free but show ads. Information sharing varies: some apps let you share with select individuals; others allow broader access to communities or provider networks. Because there is no one-size-fits-all solution to meet every client's needs, taking time to research options can help streamline the care process, as well as simplifying the coordination of care.

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Shifting the Conversation Using Activities of Daily Living Tools

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Keywords: Nurse coaching, Functional decline, Social isolation

NURSING DIAGNOSES TO CONSIDER
NANDA-I 2024-2026

1. Risk for Frail Elderly Syndrome 2. Inadequate Nutritional Intake 3. Ineffective Health Self-management

Nurse coaches support individuals in achieving self-identified health goals through behavior change and personal growth (AHNCC, 2026). They partner with individuals toward optimal health and wellness, honoring each person's unique journey while addressing the whole person—body, mind, and spirit. As healthcare continues to evolve, nurse coaches are a part of the paradigm shift from disease management to genuine health promotion.

Like many other roles in the medical profession, specialization for nurse coaches may focus on diverse populations or areas of focus. For example, my practice focuses on coaching adult women seeking to improve their lifestyles through the six pillars of Lifestyle Medicine: social connection, stress management, physical activity, nutrition, avoidance of risky substances, and restorative sleep (Frates, et al, 2021).

Elder care is another field of specialization, but it is also something that needs to be considered for all clients. Aging is an inevitability that everyone faces, and with aging comes a reduction in abilities. Initially, people lose the ability to do some of their favorite activities that require a lot of physical exertion. Then people start to notice having some issues with managing activities of daily living (ADL) and instrumental activities of daily living (IADL). These are considerations that need to be made for all clients, and that can be more challenging for aging clients and their life care plans.

Life coaching is an evolving field. For accuracy, this article details tools I have used that allow me to objectively assess functional capacity while engaging clients in meaningful conversations about autonomy, safety, and lifestyle sustainability. Rather than focusing solely on deficits (something that is practiced by some nurse coaches), I use these assessments to identify strengths, detect early

decline, and collaboratively develop individualized goals that promote independence, resilience, and successful aging along their continuum.

Types of Activities of Daily Living

ADLs are classified into basic and instrumental. Basic ADLs, also called physical ADLs, are skills required to manage one's basic physical needs, including personal hygiene and grooming, dressing, toileting, transferring or ambulating, and eating. In contrast, instrumental ADLs include more complex activities related to living independently in the community. These activities include managing finances and medications, preparing food, performing housekeeping tasks, and doing laundry.

Katz's Activities of Daily Living

The Katz's Index (Katz, 1983) assesses basic ADLs, including the following tasks:

- Ambulating: The extent of an individual's ability to move from one position to another and walk independently.
- Feeding: The ability of an individual to feed themselves.
- Dressing: The ability to select appropriate clothes and to put them on.
- Managing personal hygiene: The ability to bathe and groom oneself and maintain dental hygiene, nail, and hair care.
- Practicing continence: The ability to control bladder and bowel function.
- Toileting: The ability to get to and from the toilet, use it appropriately, and clean oneself afterward.

Assessing an individual's ability to perform ADLs is essential in determining the need for daily assistance and identifying areas where support may be beneficial. This type of evaluation is particularly important for older adults and individuals with disabilities, as it can inform eligibility for state and federal assistance programs.

Moving forward, this process will involve collaboration with the client's healthcare provider and other members of the interdisciplinary team, including nursing, social work, and coordination of health insurance coverage. This ensures a comprehensive and patient-centered plan of care.

Lawton's Instrumental Activities of Daily Living

Lawton's Instrumental ADLs (Lawton et al., 1969) require more complex thinking skills, including organizational skills. These activities include the following tasks:

- Managing transportation: The ability to plan for and manage transportation, either by driving or by organizing other means of transport.
- Managing finances: The ability to pay bills and manage financial assets.
- Shopping: The ability to organize and be aware of needed items and procure them, such as maintaining adequate groceries in the home for sustenance or shopping for necessary clothing and other products.
- Preparing meals: The ability to manage everything required to prepare a meal, including safely operating cooking devices and food storage needs.
- Housecleaning and home maintenance: The ability to clean dishes after eating, maintain living areas in a reasonably clean and tidy state, and keep up with home maintenance.
- Managing communication with others: The ability to manage telephone and mail.
- Managing medications: The ability to obtain medications and take them correctly as directed.

As individuals age and their functional status declines, they often need assistance with instrumental ADLs before requiring assistance with basic ADLs. Assisting with instrumental ADLs can be a more intermittent task than assisting with basic ADLs. With the client's permission, and within the scope of my role as a nurse coach, I collaborate with and make recommendations to the primary care team. Using objective findings from assessments such as the Katz Index of Independence in Activities of Daily Living and the Lawton Instrumental Activities of Daily Living Scale, I am able to communicate changes in functional status, safety concerns, and emerging support needs.

I have supported clients in improving mobility, enhancing medication management, strengthening self-care routines, and rebuilding confidence in their ability to live independently. Many of these interactions extend beyond physical health, addressing stress management, mindfulness practices, and sustainable lifestyle changes that promote long-term well-being.

Case Study

The following is an account of a 75-year-old retired teacher who wanted to find balance in her lifestyle regarding self-care and stress management. She was diagnosed at age 55 with Waldenstrom's, a type of non-Hodgkin's Lymphoma (Mayo Clinic, 2025). Per her oncologist, she is under surveillance now and being monitored for proteins in urine (currently 2+), as well as blood count. She has Meniere's disease (NIH, 2024) with profound hearing loss, left more than right, wears a left cochlear implant, and has peripheral neuropathy. She has been receiving chemotherapy treatments via a central line port on her chest since July 2025. The port has since been removed. She also received radiation and is being followed by her oncologist. In 2005, she suffered a bout of pneumonia. Her last body mass index (BMI) was under 18.5, which is classified as underweight (Kıskaç et al, 2022).

She has been losing weight since her cancer diagnosis, and she has not had much of an appetite.

For her employment history, she worked as a social worker at a clinic for adults. She continues to work part-time at the doctor's office, and she also volunteers at a non-profit facilitating services to the adult community.

In her social life, she is a divorcee who lives alone in a condominium. She has friends, especially a male friend, whom she has known for over 15 years, but he is now in another relationship. My client is heartbroken and has suffered emotionally over this. She enjoys plays and musicals. She also attends Al-Anon due to past relationships with family and friends dealing with alcohol.

Since knowing my client, she wanted to address filing her back taxes and organizing at home. Retirement was supposed to look one way, but her cancer changed the timeline. Her romantic hopes also changed. Now she is reorganizing both her home and her life narrative.

Nurse coaches begin their working relationships by building meaningful and trusting connections with their clients. For this client, the connection was fostered by attuning to her preferences—allowing her to guide the conversation based on what she needed most each session. Topics related to elder care are essential for life care planners to incorporate into comprehensive life care planning. A focus on lifestyle behaviors, community reintegration, and supporting individuals in making sustainable lifestyle changes is increasingly recognized as central to promoting lifelong health, functional independence, and quality of life. This perspective aligns closely with lifestyle medicine principles and the growing role of nurse coaching in supporting behavior change.

Incorporating and addressing her ADL's into her care is important in the life care planning process, especially because she is entering a new stage in her life, with retirement and downsizing from a house to a condominium. After conducting a thorough intake that included her past medical history, medications, and social history, I specifically assessed her ADLs to better understand and evaluate her current physical needs.

The client remains independent in performing all Katz ADLs. She did not report any issues with incontinence, except for getting up in the middle of the night to void every night. Despite having two hip replacements in the past, she did not report difficulties with balance during ambulation.

Although she currently has no pets, she has expressed interest in adopting a cat for companionship at home.

She continues to manage most of the activities identified by the Lawton Instrumental ADLs. While she continues to drive, the client tends to avoid driving at night and is more careful when it is necessary. Regarding finances, her ex-boyfriend would take care of some of the bills, but now she is getting accustomed to balancing her budget on her own. She does have a cleaning lady come once a week to assist with some of the heavy chores, such as washing clothes and cleaning the bathroom. Living in a condominium relieves her of any responsibility of home maintenance. She still maintains an independent way of living and expressed an interest in traveling now that she is retired, but first wants to rebuild her health and receive approval from her primary doctor.

Medications

The following is a list of her current medications, where she uses a medication tray mainly for tracking adherence, since she takes medications in the morning, afternoon, and evening. The medication tray still works for her as she refills her own medications at this time.

Medication	Dose
Melatonin	60 mgs. daily and now reduced to 6 mgs.
Multivitamin	Daily
CBD gummies	Daily for rheumatoid arthritis
Iron supplement	Twice a day for anemia
Miralax	Powder packet daily for constipation
B-complex	Daily
Alpha lipoic acid	600 mgs. daily omega 3's
Losartan	50 mgs. daily hypertension
Neurontin	300 mgs. three times daily peripheral neuropathy
Prednisone	5 mgs. daily for weight gain
Duloxetine	100 mgs. daily for chronic musculoskeletal pain
Felodipine	5 mgs. daily hypertension

Goal-Setting Template: "The Energy & Mass Plan"

Being a social worker, she will likely respond well to a lesson plan or SMART goal format that feels like a collaborative "clinical protocol" rather than just a suggestion.

Focus Area: Nutritional Density & Sarcopenia Prevention

- **The Goal:** Increase caloric intake by 250–500 calories/day without increasing GI distress.
- **The Action:** See a registered dietician. "Power Pairing." Adding a high-quality fat or protein to every current meal (e.g., adding avocado to toast or collagen protein to tea/coffee).
- **Measurement:** Weight check once weekly (same time/scale) to monitor the efficacy of the 5mg Prednisone.

Focus Area: Functional Mobility (Fall Prevention)

- **The Goal:** Maintain muscle mass in lower extremities to support hip replacements and counteract neuropathy.
- **The Action:** 5–10 minutes of "Sit-to-Stand" exercises or heel-to-toe balances (near a sturdy surface) 3x per week.
- **Measurement:** Self-report on "steadiness" during her volunteer shifts.

Waldenström's Survivorship: Clinical Watch-Items

Based on recent oncology guidelines (including those often utilized at her specialist clinic), the following table details the key red flags and monitoring points for a client in her position.

Metric	Survivorship Consideration
Proteinuria (2+)	Monitor for peripheral edema (swollen ankles) and "foamy" urine. This is a primary indicator of disease progression or renal amyloidosis. She receives follow up labs from oncology. Wears compression stocking 90% of the time.
Hyperviscosity Symptoms	Even though she is "under surveillance," she is asked about new headaches, blurred vision, or epistaxis (nosebleeds). These can indicate a spike in IgM proteins.
The "Melatonin 6 mg"	My client used to take high-dose melatonin (60 mgs.), which is often used in integrative oncology to improve the efficacy of chemotherapy and protect bone marrow. She takes this at the exact same time each night to prevent daytime grogginess that could lead to a fall.
Neuropathy Check	Since she takes Neurontin and Duloxetine, monitor if the neuropathy is stable or progressing. New numbness in the hands might affect her ability to manage her cochlear implant batteries.
Biotin	10,000 units daily due to reports of hair loss during chemotherapy and radiation.

Coaching Strategy: The "Retired Colleague" Approach

Because she continues to work part-time and volunteer, her identity is tied to being capable. We work on different themes, like the following.

- **Validation:** I acknowledge that her desire to work is a protective factor for her mental health.
- **The Pivot:** Frame rest as a clinical intervention. Instead of taking it easy, I suggest scheduled recovery periods to ensure she can continue her non-profit work long-term.
- **QiGong Integration:** QiGong is the traditional Chinese Medicine practice that works on "qi" (pronounced "chee") or energetic life flow to prevent blockages, which could pose as health problems (Cleveland Clinic, 2025). These practices involve movements throughout the body and involve no equipment, and can be done sitting or standing. We do a segment of QiGong for about 5 minutes with every session. I always ask if she has any limitations or new aches/pains I should be informed about. We focus on certain areas, from her hands down to her feet next. This helps her map her boundaries despite the peripheral neuropathy.

Emerging Vulnerability: Social Isolation

The key shift in her case appears not to be physical decline, but psychosocial change following the end of her relationship. Her social ecosystem has weakened. This is where support-system mapping becomes critical.

Research consistently links social isolation to managing the following:

- Reduced physical activity
- Poor nutrition patterns
- Increased depressive symptoms
- Cognitive decline risk
- Higher morbidity and mortality

My client is not socially isolated in an absolute sense, but she may be experiencing situational loneliness and loss of primary attachment. This can still influence function. When viewed through a life care planning lens, the issue is not simply that she is alone — it is that loss of relational structure may be eroding daily routines and engagement, which in turn affects functional capacity. To deepen the assessment, I have explored several options with her to consider the following questions:

- Who does she call first when something goes wrong?
- How often does she leave the house socially (not for errands)?
- Has her appetite or cooking frequency changed since the relationship ended?

- Is she sleeping well?
- Does she report loneliness, or just "being alone"?

There are other tools that can be used. Fortunately, she is not in a crisis, and I have screened her for suicidality. She also sees a psychiatrist, and she receives further workup.

Bigger Picture

Her case illustrates an important elder-care principle: functional decline is often social before it becomes physical. By identifying that her core vulnerability is isolation, not inability, I am positioning the care plan toward restoration of engagement rather than escalation of dependency. These strengths suggest she remains largely independent in instrumental activities and is functioning at a relatively high IADL level. I plan on using these tools again in the next 6 months, as it creates a measurable functional trajectory, allows for monitoring of subtle executive change, and differentiates emotional fluctuation from cognitive decline.

This experience demonstrates that effective nursing care is not limited by physical proximity. I feel I am stewarding stability as I screened her for safety, and she trusted me at her most vulnerable moments (chemotherapy, radiation, and romantic loss). A good coaching relationship is reciprocal in growth (not in dependence), there is respect for the client's resilience, and the work feels meaningful. That, and having some grounding in evidence-based assessment with the above-referenced tools, nurse coaching can empower individuals to take ownership of their health and move toward greater independence and vitality.

Conclusion

By collaborating with life care planners during this critical stage of client care, nurse coaches can provide insight into what is needed based on the individual. People's physical abilities decline at very different rates, making it a challenge to predict what is needed in a life care plan. Even though physical decline is inevitable, there is a lot more that needs to be considered to determine what a patient actually needs. Their mental and emotional states do affect their ADLs, which may affect their physical abilities temporarily. There will be times when the best solutions involve helping a client connect with a support network or mental health professional.

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