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CASE STUDY: EFFECT OF PERSON-CENTERED CARE AT CARE HOMES TO ENHANCE THE QUALITY OF LIFE OF OLDER ADULTS IN PAKISTAN

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ABSTRACT
The issue of ageing is becoming more and more challenging. According to a different study, physical abuse, neglect, poor health, and lack of respect for older individuals contribute to their isolation. Some children could not take responsibility for their parents, leaving no one to look after their needs. Moreover, therefore, they ended up residing in nursing facilities or old age homes. However, old homes provide services that could enhance older people's quality of life. However, most old age homes only give the most fundamental care and assistance. Consequently, older people who live in old-age homes lack holistic and person-centered care. (Hayat, Khan, and Sadia, 2016). Person-centered care encompasses the elements of care, individual needs, and treating individuals with respect. Person-centered is a comprehensive and integrative strategy intended to sustain older people's well-being and quality of life. This chapter aims to evaluate the effects of person-centered care to enhance the quality of life of older adults at old age homes.

KEYWORDS: older adults, person centered care, quality of life.

INTRODUCTION

The population will continue to age rapidly over the next few decades (Lutz et al., 2008), and there are severe economic and social implications of increasing longevity and a rapidly ageing population. Increased longevity is noticeable in developed countries compared to developing countries or Eastern cultures and societies (Bloom et al., 2010).

In many Eastern cultures, older adults are also considered a source of wisdom and transformation of culture and traditions. (Baltes and Smith 1990). Moreover, this wisdom is an essential part of facilitating successful ageing. The research has also confirmed that wisdom is positively associated with life satisfaction (Blazer, 2006). Other research also suggested that "Wisdom is more persistent among the financially and interpersonally deprived respondents and individuals with low perceived social support such as minorities, older adults, women, and individuals with illiterate background" (Brugman, 2000). However, under the effect of globalization, children are more often living separately from their parents; they aspire to pursue a higher level of education abroad or migrate to pursue better income opportunities, which affects the quality of life of older adults in developing countries and eastern societies. This changing family living pattern has resulted in social isolation, loneliness and a lack of sharing wisdom and tradition (Lowsky et al., 2014).

Furthermore, therefore, the issue of ageing is becoming more and more challenging. In developing nations like Pakistan, where 9 million people are 60 or older, 42 million will be by 2050 (Kalache et al., 2005). Family structures are changing from the joint family system to the nuclear family, causing increased problems for older family members. Elderly parents are no more or have little authority to make decisions for the family. According to Sabzwari and Azhar (2011), older individuals experience loneliness and a lack of social support when their attempt to move in with and live with their children. According to research evidence, older people often do not receive support from their relatives, not even for the most basic needs. As a result, older adults often experience challenges and end up living in a care home of old age home. Furthermore, to fulfil the basic needs and care, caregivers need more academic competencies and training to care for older adults in old age homes. (Ali & Kiani, 2003).

According to a different study, physical abuse, neglect, poor health, and lack of respect for older individuals contribute to their isolation. Some kids lose their parents, leaving no one to look after their needs. The parents who are, as a result, wind up residing in nursing facilities. Although old age homes provide services that could enhance older people's quality of life, most homes only give the most fundamental care and assistance. Older adults who live in old-age homes lack holistic and person-centred care (Hayat et al., 2016).

Hence, the ageing population problem has been a significant worry for policymakers in industrialized and developing nations during the past 20 years. However, it has differing effects on wealthy developing countries and underdeveloped ones. Soon, there will be more elderly than children and a more significant number of significantly older adults than ever. As a result, "Old Age Homes" are essential in providing improved care for older people as time goes on. So they can live their lives in a dignified and autonomous manner (Qidwai, 2018).

Moreover, as we age, we must maintain physical, mental, social, psychological, and spiritual health. Therefore, a comprehensive strategy and person-centred care are needed to improve the quality of life for older adults in old age homes. As a result, the nonprofit organization VCARE Social Welfare Society for Active and Healthy Ageing launched a person-centred care approach and trained their staff to provide person-centred care. This chapter will discuss the case study to see the outcome of person-centred care and the importance of inculcating person-centered care in a policy agenda of public health in Pakistan.

Define person centered care

Person-centered care encompasses the elements of care, individual needs, and treating individuals with respect. It is a comprehensive and integrative strategy intended to sustain older people's well-being and quality of life. Every person wants to spend their life with dignity and according to their personal preferences; thus, older adults require this kind of care as they age and face more obstacles. It provides for the requirements of a high-quality existence. That makes it possible for them to have meaningful lives and pursue their interests. This method should be the cornerstone of residential care, treatment, and support (Kim, 2017).

For healthcare to be holistic and compassionate, it requires effective communication between individuals receiving care and those delivering it. It is necessary to take action to support the capacity-building of better-informed and empowered people, families, and communities that can actively participate in healthcare.

Concept of Quality of life

There is no single definition of quality of life, as researchers from different philosophical, sociological, medical, and psychological sciences have different definitions. According to World Health Organization (WHO 1997, pg 1), quality of life is "the perception of a person's life in the context of culture and value system in his/her life." Moreover, Holmes (2005) defined the quality of life as one's life circumstances and satisfaction.

However, in some literature, quality of life has also been used as a synonym for life satisfaction though the meaning of Life satisfaction is a little different and challenging to define as sometimes it had been "used interchangeably with happiness. However, they are indeed two separate concepts. Life satisfaction is the evaluation of one's life, not simply one's current level of happiness" (Park, and Peterson, 2010, p12). The researcher Ed Diener has explained life satisfaction as "An overall assessment of feelings and attitudes about one's life at a particular point in time ranging from negative to positive". He also elaborated two-term (Life satisfaction and quality of life) "Life satisfaction is the degree to which a person positively evaluates the overall quality of his/her life as-a-whole" (Diener et al., 2009). The notion clearly shows that life satisfaction cannot be used alternatively with the term quality of life.

Moreover, in earlier literature, quality of life has also been used interchangeably with subjective well-being (Dodge et al., 2012). "Subjective well-being (SWB) is the personal perception and experience of positive and negative emotional responses and specific cognitive evaluations of satisfaction with life" (Diener et al., 2002, p. l63). So, in simple words, SWB is the individual evaluation of the quality of life (QoL) and therefore unites with the definition of QoL (Diener et al.; S., 2002). Moreover, quality of life can be interpreted by looking at one individual's different aspects of well-being and how satisfied and happy one is with everyday life circumstances (Diener et al., 2018). According to Balan and Girija (2015), quality of life is a general feeling of happiness, not a temporary experience but a long-term well-being.

The above discussion was from the perspective of Western society on how quality of life is perceived. However, eastern society, predominantly Muslim societies like Pakistan, has a little different perspective on the quality of life. Muslims have a significant impact of their religion (Islam) on their "lifestyle and ways of thinking" (Al-Aidaros, and Shamsudin, 2013). Abu-Raiya and Pargament (2011) in his literature had suggested that while assessing "Muslims' lives and well-being, there is a need to understand the Islamic religion when dealing with Muslim populations, and not doing that could give an incomplete and one-sided picture of Muslim's understanding of the quality of life" (Al-Aidaros. and Shamsudin, 2013).

For Muslims, the good life or quality of life is when one follows the ethics of Islam (Rania, 2006). Ogbonna and Ebimobowei (2011) stated: "Ethics reflected in the principles that a person uses in governing his/her actions

and the personal standard by which a person distinguishes the right from the wrong described that ethics direct Muslims to have a good life and live well" (Al-Aidaros & Shamsudin, 2013). Furthermore, in the Islamic perspective, "God is the only reality, and nothing else possesses authentic existence, 'the full realization of this ultimate truth constitutes 'loss' of self in the One" (Joshanloo, 2013). Islamic thought directs one to live a good life; one should have faith in Allah and practice of principles of Islam as it covers all the aspects of life (spiritual, economic, social, political, and the family) (Joshanloo, 2013). It is believed that only having true faith in these beliefs and living a "life based on the ordinances of Islam in all aspects (Quran 10:63–64) can lead to the satisfaction of the individual's physical and spiritual needs, an actualization of their potential". Such a viewpoint could fit the eudaimonic view that emphasizes actualizing human potentials and satisfying true human needs" (Joshanloo, 2013).

Furthermore, some Islamic literature "holds that Muslims should not pursue hedonistic pleasures as the primary goal of their lives" (Joshanloo, 2013). Although positive emotions and pleasure are essential to Islam, they are considered secondary and placed after the eudaimonistic determined (Joshanloo, 2013). Moreover, some Muslim writers generally agree with the Aristotelian notion that to obtain happiness; one needs to know all aspects of humankind, all its capacities and abilities, deficiencies, and needs (Husain, 1998). Therefore, the Islamic viewpoint of the quality of life is when people follow the ethic of their religion and trust God to achieve the best in life.

Therefore, it is a distinction between the definitions of all three concepts, life satisfaction, well-being, and quality of life. Life satisfaction is the individual's evaluation of one's life, while quality of life refers to general well-being. The quality of life is broad and depends on how an individual measures the 'goodness' of multiple aspects of their life. "These evaluations include one's emotional reactions to life occurrences, disposition, sense of life fulfilment and satisfaction, and satisfaction with work and personal relationships" (Diener & Lucas, 2000). Therefore, three of these terms cannot be the same entity or cannot be used interchangeably.

However, quality of life can vary from one culture to another. Therefore, it may be misguided to generalise the definition of QoL cross-culturally.

However, when the quality of life was assessed using CASP (control, autonomy Self-realization and Pleasure) for older adults cross-culturally living in the community, it was identified that Assessing the quality of life using CASP measure in fatalist culture is appropriate. Fatalism may be consistent with the belief that events are caused by a determining principle or force in the universe, such as God. However, researchers have also found out that fatalistic Individuals can still believe that some of their actions may change certain events (Belluomini, 2020).

The domains like autonomy and control in CASP are also present in fatalist culture, which is evident in Surani's (2023) study. The study participants believe that health and illness are from God, and they do not have control over it. However, they also acknowledged that some illnesses are because one's behaviors and lifestyle choices, as one of the study participants said, 'I had a major heart attack last year because I was a chain smoker. So, one needs to take care of their health' One of the other participants also said that 'health is a blessing from God. We are responsible for taking care of it. A few study participants also highlighted that whether the illness is physical or psychological, it is an affliction from GOD. However, illness can also come from cultures; eating, food habits, and behaviours play a vital role in health and illness. Therefore, it is evident from their responses that they believed in fate and their ability to choose.

Moreover, A study conducted in Karachi, Pakistan asking about middle-class women's perception of autonomy identified that older women are given more autonomy. However, autonomy is more common in men, even young ones (Stewart et al., 2006). Furthermore, the study was conducted in Jamshoro urban city in Pakistan, where the interview was conducted to understand the concept of autonomy in women; the study identified that women have autonomy even in fatalist culture, but it is categorised as "bounded autonomy or limited autonomy" where women make independent decisions but thinking more about their family than herself (Khatwani, 2017). Moreover, one of the studies conducted in Karachi, Pakistan, suggested that autonomy and independence are socially constructed, and their meaning are deeply rooted in cultural specificity (Mumtaz et al., 2011).

Moreover, the literature also suggests that socio-economic groups are also indicators that impact autonomy and control. The people living in the low-income group do not have much freedom to look after their health, have healthy food, and take treatment. Quality of life is very individualistic; Netuveli (2008) mentioned in his study that most older adults evaluate their quality of life positively based on social contacts, dependency, health, material, circumstances and social comparisons' (Netuveli, 2008). Autonomy is a more critical aspect of person-centred care where the person is vital to involve in their care decision-making. Moreover, the model, like person-centred care, when used in a country like Pakistan, needs to be culturally appropriate.

Concept of person center care

For older people and those who care for them to meaningfully express choices and exercise self-determination at every level of daily life, person-centered care encourages the development of both long- and short-term living spaces and community-based settings.

This transformation may require modifications to organizational procedures, physical settings, connections at all levels, and workforce models. If properly implemented, these changes will improve client outcomes and the performance of staff members (Lown, Shin, and Jones, 2019). Person-centered care is about providing or fulfilling the client's physical, social, or psychological requirements.

Person-centered care should be considered interdisciplinary to consider the possibility that a person may need the aid of several professions. Person-centered care is not a medical model but a combination of medical and social models. Working this way requires comprehending that people can influence and improve their health rather than seeing them as passive patients or disease victims.

Person Center Care (PCC) is suited for age-friendly communities since both underlines how crucial it is for older adults to be noticed, actively included, and helped when necessary. According to the new smart age-friendly ecosystem framework, nursing homes that offer PCC make excellent age-friendly living settings. In terms of older citizens, PCC refers to recognizing and appreciating the individuality of both carers and care users. Older adults with complex care needs are offered the chance to continue living how they wish through PCC. To provide older people with the best care possible, it is essential to be sensitive to their needs, desires, and possibilities. The academic collaborative center older adults: A description of co-creation between science, care practice and education to contribute to person-centered care for older adults. (Luyckx et al 2020). In addition, according to self-determination theory, everyone has an inbuilt need for competence, relatedness, and autonomy in terms of their psychological needs to maximize well-being (Deci & Ryan, 2000). These requirements, which may alter in significance based on a person's circumstances, environment, or past experiences, can be organized through person-centered care. Thus, some daily preferences may evolve more quickly than others (Van Haitsma et al., 2014).

Professionals usually underrate how much patients can take control of their health. Many patients/residents would be willing and even pleased to do so if their abilities were acknowledged, supported, and strengthened rather than being discounted and degraded. Families, carers, and skilled advocates should be actively involved in the care planning so people with poor mental capacity can assume more responsibility for their care. (Coulter & Oldham, 2016).

The fundamental topics covered by person-centered care included the importance of person-centered care, and some life skills components included communication skills, problem-solving and decision-making skills, and self-awareness. However, the essential component was Communication abilities that ensured clients and their families received correct, timely information to communicate effectively. All essential communication skills are active listening, questioning, handling ambiguous responses, and learning to apologize, respect, and comprehend the client's life. The client's viewpoints and perspectives were given more consideration. Professionals working in health care sectors, especially in care homes, nursing homes and old age homes, must exhibit essential traits such as empathy, mindfulness, client involvement, emotional intelligence, Negotiation skills and self-awareness. Moreover, humor and a kind demeanor can help older adults feel more connected to daily life. It can also help them deal with issues with consistency and predictability. Enabling customers to manage their own emotions.

Additionally, the person-centered care approach designs, implements, and evaluates client care based on collaborative relationships with family members. (Sanerma et al. 2020)

Now the chapter will move to real-life case studies providing person-centred care.

Effects of person centered: Case studies from old age home.

Client A: Abandoning everything to live the life of your dreams

Mr A 65-year-old gentleman who lost his power, property, name, prestige, and family and involved himself in drugs and alcohol. He had a family business and was brought up with humble family values. However, when tangled in an alcoholic gathering, he left every blessing behind for his desire and choice. He became a chain smoker with an alcoholic lifestyle. Consequently, he confronted isolation, poverty, and depression when his family left him alone.

One of his friends saw him in an awful condition and heard about VCARE, which provides long-term care to older adults with protection, care, and rehabilitation. VCARE kept him in a separate room to provide person-centered care and involved his friend in a care plan. Mr. B showed withdrawal symptoms in various activities arranged for him. He seemed Irritable. His changing moods, depression, and anxiety tiredness controlled him harshly. His most severe withdrawal manifestation was delirium tremens, hallucinations, and seizures. He was sweating, Goosebumps, vomiting, nervousness, insomnia, and muscle pain. In support of his friend and general physician guidelines and involving him in his care plan, we worked on his diet, physical exercises, and behavioral therapy; cognitive Behavioral Therapy (CBT) is a proven method for alleviating the burdens of alcoholism. We applied CBT to identify the negative thoughts and behaviors of Mr. and replaced them with positive ones. After some time, Mr. A involved himself in person-centered care and chose the required care. This empowered him, and now Mr. A helps other senior citizens and assists them with walking, feeding and outings. He is an alcohol-free older adult and spends his content and productive life on the premises of VCARE. He goes for his prayers, offers his services at VCARE and helps the staff of VCARE to serve other elderly residents.

Client B: She adheres to the motto "Love the Life You Live"

Ms. B, an elderly of 72 years, was a professor at a native college. She is specialized in Islamic studies with an M.A. degree and spent her whole life in great prestige. At 70, she was diagnosed with Dementia that progressively deteriorated her mental and physical health and made her dependent on her relatives. She adopted a child, made him a doctor, and sent him to the USA for his bright future, but at the time of her assistance, he could not make it to backing his mother in her distressed time due to his busy schedule.

At that time Ms. B was brought to VCARE by her cousin with a hip bone fracture and multiple bruises on her body. She was malnourished and in severe depression as she had spent six months in a dark room under the supervision of one lady. Her body was completely stiff and fragile.

At VCARE, involving her relative and various health care providers, the care plan was developed, focusing on her diet and physical therapy with holistic rehabilitation treatments. She was also involved in psychotherapy sessions by involving her in physical and recreational activities with her consensus and in her care and working on her mood swings by involving her in Eco therapy and environmental remedies that substantially positively impacted her overall health.

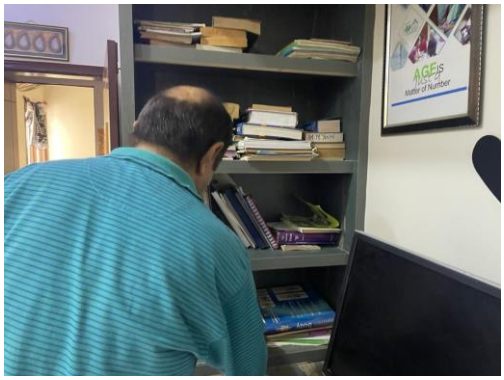
Now Ms B is an active lady who walks independently, always enjoys her meals, and demands different snacks for her party time. She is a leading lady among VCAREs residents for their activity time.

Client C: Live a Life with dignity

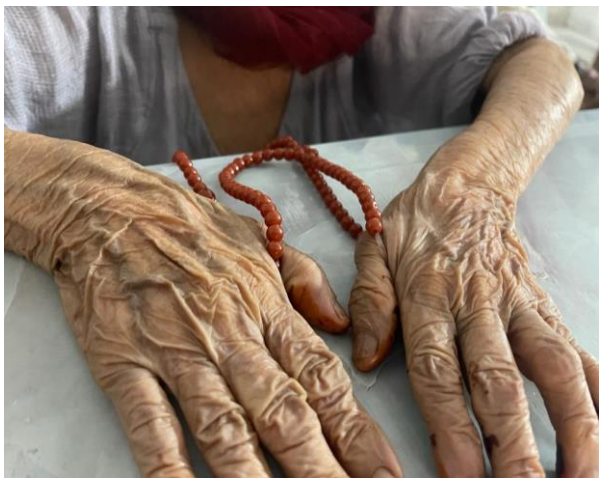
He is a gentleman who spent his whole life in a dictator way and had his business in diverse regions of the Country, even extending it to an international level. However, one Scam turned his life's destiny and deported him back to Pakistan, where he was used to living on roads with severe skin diseases and lost minded.

A social worker brought him to VCARE for a secure shelter. We found Mr C was a stubborn guy who used to spend his whole life in Monopoly; this elderly was a challenging task for VCARE to make him understand that life has taken a U-turn and he has to go with the flow—that time used only an active listening strategy one of the critical component of person-centred care, to understand him and build trust. Where we conducted one-to-one sessions for his counselling and motivation to restart a life journey in a new way with courage and confidence, this type of psychotherapy focuses on changing both negative thought processes and behaviours that contribute to depression symptoms. In four months of regular counselling, Mr C. improved his mental, social, physical and spiritual well-being, which motivated us to continue with the same rehabilitation tactics to achieve his New life goal differently. Today Mr C. is involved in his care and is empowered through various activities. He has become a strong pillar of the VCARE family.

A widow who had worked her whole life in worries and challenges without having a child, but once she earned a bit to manage her bread, she adopted a boy from her community and gave him motherhood compassion with all her efforts. However, when the time came to start their son's life after his marriage when he got separated to lead his own family with his wife and two kids, MS D was again alone and isolated—lifetime-long hours of hard work and fasting for extended hours made her emotionally and physically weak. This whole time confined her to bed that time; her community members brought her to VCARE, where she could not even stand; her hair and head were covered with fungus. We had involved the client for her consent and health care provider. We cut the hair to remove the disease from her head and started giving her regular bath to primary her hygiene. A range of motion and gate therapy played a vital role in her mobility; we gave her walking aids to move with the assistive device that encouraged her to walk again and gave her the hope of independent life. Her mood swings were again a challenge, but due to her expressive nature, we applied the talk therapy and engaged her in many talking and expressing activities. With all this support, Ms. D got empowered, and now she helps with kitchen chores too, cutting vegetables, flour kneading, and flower making. Her jolly nature and prayerful hands are always a blessing for every visitor and people of VCARE.



Client D: Determine and improve quality of life.



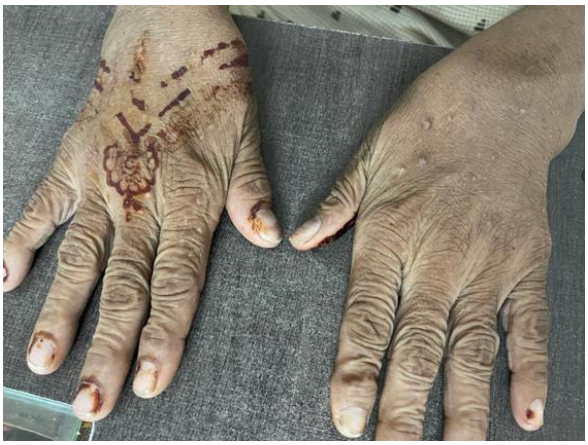
Client E: Respect and Dignity improves quality of life.

MR E is a CIA inspector who spent his whole life in a dignified manner. He worked for the Government of Pakistan and encountered many criminals. His victorious life was an example for his whole family and the state. However, as an individual, he was a sensitive and deep thinker person who loved and chose a girl as his life partner. However, some unknown reasons and refusal from her family made Mr. E had depression. At that time, he decided not to get married for his entire life; that decision was shocking news for his mother. She requested her to restart his life and go with the flow, but that decision of his life made his mother sick, and she died just for the pain of his son. His mother's death took him into more profound grief and distress, and he started living alone with multiple drugs. In that situation, his brother brought him to VCARE for rehabilitation and shelter for the long term, as the family could not manage to give him a stay in their private life. VCARE had many active listening sessions with him, and with his consent, his rehabilitation process had been started. It involved him in group therapy sessions. After some sessions, he happily approached for a walk in the park. These environmental therapies and group sessions significantly impacted his mental health and helped him to recover from depression.

Today Mr. E is a productive and active resident of VCARE who helps other older residents with mobility and goes shopping for his regular needs on his own.

Client F: Life gives another chance to empower oneself.

Ms F lived her peek life and career in UK Manchester as a chef. She is a bold and confident lady. After spending 16 years in the UK, she returned to Pakistan when her mother was diagnosed with cancer. She windup everything and started caring for her sick mom. When she lost her mom, she affected her profoundly and took her depression and cardiac issues. She started living alone at home and became weak. One social worker brought her to VCARE to make her life worth living. VCARE started active listening sessions and identified her needs and her interests. as she had worked for many years and always wanted to work and be independent with a couple of communication sessions and self-awareness sessions. She offered her service to help in kitchen activities at VCARE. Moreover, therefore healthcare professionals such as her cardiologist were involved in her care plan, and on his consent, we accepted Ms. F's offer to work as an assistant cook, and we offered her a small stipend as a reward for her hard work and independence. Her determination is an example for every woman at VCARE.



SUMMARY

This Chapter has explored the effectiveness of person-centered practice with older people. The practice at VCARE emphasizes partnership, which works between care workers, family and different health care providers and older people based on a 'negotiated relationship' because person-centered care is not a medical model and should be viewed as interdisciplinary to acknowledge the possibility that a person may require the assistance of multiple professionals.

Person-centered care should be integrated into the healthcare system at all levels, from governmental policies to the delivery of care by individual physicians. Better care integration initiatives should begin with a patient-centered awareness of the patient's perspective, emphasizing individualized care planning and care coordination more than organizational integration. These mechanisms should be redesigned with input from the patients. Residents or clients.

Moreover, professional development is equally crucial; undergraduate and postgraduate training should include a core component of how doctors and patients engage and discuss treatment regimens for all medical fields. Patients can provide a valuable contribution and assist in bringing about the culture change required to make person-centered care the standard of care in various

areas, including service reconfiguration, medical research, commissioning, training, and teaching.

Furthermore, it is essential to put Efforts to empower patients and residents by educating, involving, and empowering them as part of person-centered care. This includes techniques to improve health literacy, facilitate collaborative decision-making, and encourage and support self-care. The idea of person-centered care is fundamentally based on respect for people. Therefore, the principle of person-centered health care is the rights of people whether living in care homes, nursing homes, old age homes or hospitals. Person-centered care necessitates the development of a therapeutic narrative between the patient and the professional based on respect, mutual understanding, and sharing common knowledge.

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