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Organizing a Proper Home-Care Environment for an Elderly Couple Living Alone in which the Husband Repeatedly Visited the ER and His Wife Suffered from Cognitive Impairment

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Abstract

Objective: The study aims to clarify the nursing practices to organize a proper home-care environment for an elderly couple living Alone in which the husband was frequently taken to the emergency room (ER), even though he was responsible for caring for his wife with cognitive impairment.

Methods: A case study approach was employed to clarify the process of multidisciplinary coordination among medical professionals based on retrospective analysis of descriptions for supporting an elderly couple. A nurse organized relevant information about the subject family, assessment results, and support practices developed by medical professionals to describe the process of nursing interventions. She called for a series of multidisciplinary conferences involving the patient's family and relevant parties, and shared details of the change in process observed for the family at a family nursing science workshop to reflect their nursing practices. Regarding ethical consideration, the facility director, patient, and his family received a verbal explanation of this research and consented in advance to participate in the research.

Case and Nursing Status: The subject was a male patient in his 80s who repeatedly visited the ER due to losing consciousness after receiving surgery for spinal stenosis. He lived with his wife, also in her 80s, who suffered from cognitive impairment. Although no abnormality was observed in image analysis and blood test, he was involuntarily hospitalized due to his frequent need for transportation to the ER. The patient strongly insisted on being discharged, while the medical professionals and his eldest son recommended keeping him hospitalized. A joint conference was called that included the patient, his wife, his eldest son, the ER doctor, ER nurses, home-visiting nurses, and the care manager to resolve the situation. During the meeting, the opinions of each party and the direction of the support strategy were shared, leading to a discharge as the patient desired.

Discussion: The issue of *rourou kaigo* (the elderly caring for the elderly) is a problem requiring immediate and utmost attention in Japan. Mutually supportive collaboration between medical professionals and people in the community is essential to address this issue in an aging society. Establishing a system where medical facilities, municipalities, communities, and family members can work together effectively is essential to build a community where older adults can continue living in their familiar environments with a sense of security. In this study, effective interventions were achieved successfully through the joint conference organized by the nurse to coordinate support practices and establish a proper home-care environment involving the patient, his family, the medical team, and the home-care team.

Conclusion: The medical team and the home-care team reached a mutual understanding by reflecting and organizing differences in their positions, values, and conflicts, thereby enabling all relevant parties to focus on the patient's and family's capabilities, leading to a successful establishment of a proper home-care environment.

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Introduction

The portion of *rourou kaigo* (the elderly caring for the elderly) families, in which the caregiver and recipient are both at least 65 years old, is in an increasing trend due to the rapid aging of society and low birthrate in Japan, posing a serious social issue. Diversification in family structures is a primary background factor of the problem. In addition, the growing trend of non-marriage and the increase in unmarried individuals are considered as the factors causing the increase in households with only older adults. The portion of rourou kaigo families was 40.1% in 2001 and rose to more than 60% in 2024[1]. Moreover, the portion of super rourou kaigo families, whose caregiver and recipient are both over 75 years old, has increased to 35.7% [2].

Problems in *rourou kaigo* families include tremendous physical and mental burden for the caregivers, for whom the decline in physical functions is also a pressing matter. The caregivers often become socially isolated due to the demanding care duties. Furthermore, the caregiver often has their own chronic diseases. Providing care is a physically and mentally demanding task, frequently leading to a

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decline in the caregiver's health. This can eventually result in various tragic developments, such as caregiver neglect, murder-suicide, or nin'nin kaigo (the cognitively impaired cares for the cognitively impaired).

Measures have been taken in Japan to address these issues, recommending caregivers use various Long-Term Care Insurance (LTCI) services, such as home-visiting nursing service, adult day care service, and short-term stay service. However, these caregivers often do not ask for help for various reasons. Some are unwilling to bother relatives or others, while others do not want to accept support from municipalities, leading to the situation of *rourou kaigo*.

In this case study, an elderly husband, who is responsible for the care of his wife with cognitive impairment, insisted on receiving home care despite his frequent visits to the ER, and medical professionals successfully intervened by organizing a proper home-care environment.

Objectives

The study aims to clarify the nursing practices for organizing a proper home-care environment for an elderly couple in which the husband, living with a cognitively impaired wife, was frequently transported to the emergency room (ER).

Methods

The work employed a case study approach based on the descriptions organized by a chief nurse of the intensive care unit (ER) regarding nursing practices of in-hospital and home-visiting medical teams in preparation for the subject patient's discharge.

Data collection

Collection of family data and its assessment were conducted using methods widely employed in the field of clinical ethics: the Four Topics Method by Albert R. Jensen [3] and the ABC-X model by Ruben Hill4) presented in Family Crisis Theory. Intrafamilial ethical conflicts and crisis issues were extracted from the assessment results, and relevant nursing interventions for the family were organized chronologically. The validity of the ethics conference, in which the ward nurses attended to the patient and the donor, the outpatient nurses, and the doctor in charge participated was also examined.

Various types of medical professionals work as a team in an ER. In this study, the nursing practice of patient discharge preparation organized by the chief nurse of the ER ward was primarily analyzed and described. The chief nurse in the ER reviewed nursing records and her own nursing practices and chronologically organized relevant data, including the patient's conditions from admittance to discharge, patient care details, family status and assessment, and nursing practices for the patient's family. The descriptions of nursing practices were primarily focused on collaboration between the ER medical team and the home-visiting medical team in preparation for the patient's discharge.

Analysis

A workshop to discuss the case using the nursing progress chart was held, and nursing science researchers and nursing practitioners attended. The nursing progress chart summarized the patient's progress and corresponding nursing practices in short text, and the workshop participants discussed the case from various aspects, including questions, reasoning, and intentions behind the decisions at each stage, in an attempt to enhance the reliability of the nursing process.

Ethical consideration

Approval for research publication was obtained from the facility where nursing practitioners who participated in this study were affiliated. The patient's family received verbal explanations and verbally consented in advance to participate in the research.

Details of the Case

Family structure (Figure 1)

The patient was an 84-year-old man who gradually developed difficulty walking and used a walking cane after surgery for lumbar spinal canal stenosis. He received weekly home-visiting care support for his daily living. His 80-year-old wife suffered from a cognitive impairment, exhibiting behavioral symptoms such as wandering. Their 48-year-old and 46-year-old sons were both married and lived in different prefectures.

The patient was found in a state of decreased level of consciousness by his wife in September 2025, when he was taking a bath. The wife called the neighbors for help, and he was transported to the Emergency Room (ER) of the X University Hospital by ambulance. Initial diagnosis indicated symptoms of heat stroke and 3% second-degree burn on his lower leg. The burn was treated at the ER Center. He showed recovery and was discharged the next day. The treatment summary report describing the development of the incident and treatment details was forwarded from the ER Center to the Home-visiting Nurse Station that supported the in-home treatment for the patient.

Three days after the discharge, the Home-visiting Nurse reported that "the patient's consciousness level is low" and requested an emergency transport. The patient was again transported to the same ER Center. By the time he arrived at the hospital with his wife, his consciousness level had returned to normal. He was allowed to return home without hospitalization because the neuroimaging diagnosis and blood test results did not show any abnormalities. He could walk independently, and above all, he strongly insisted on returning to his home.

Two days later, his wife reported that his consciousness level had declined again, and he was transported for the third time to the ER Center of the X University Hospital, accompanied by a home-visiting nurse. He regained consciousness when he arrived at the hospital, was able to engage in conversations, and declared that he had no intention of being hospitalized and requested to be allowed to return to his home. Although no evident conditions requiring treatment were identified, the doctor in charge determined that it was challenging for the patient to perform activities of daily living (ADLs) in his current condition and hospitalized him involuntarily.

Post-admission development within the patient's family

The patient's wife began to exhibit unstable behaviors alone at home after her husband's emergency transportation to the hospital. She was found and taken into protective custody by the police while wandering around the neighborhood barefoot for half a day, looking for her husband. The eldest son requested inpatient treatment for his father due to his frequent emergency transports. However, the patient

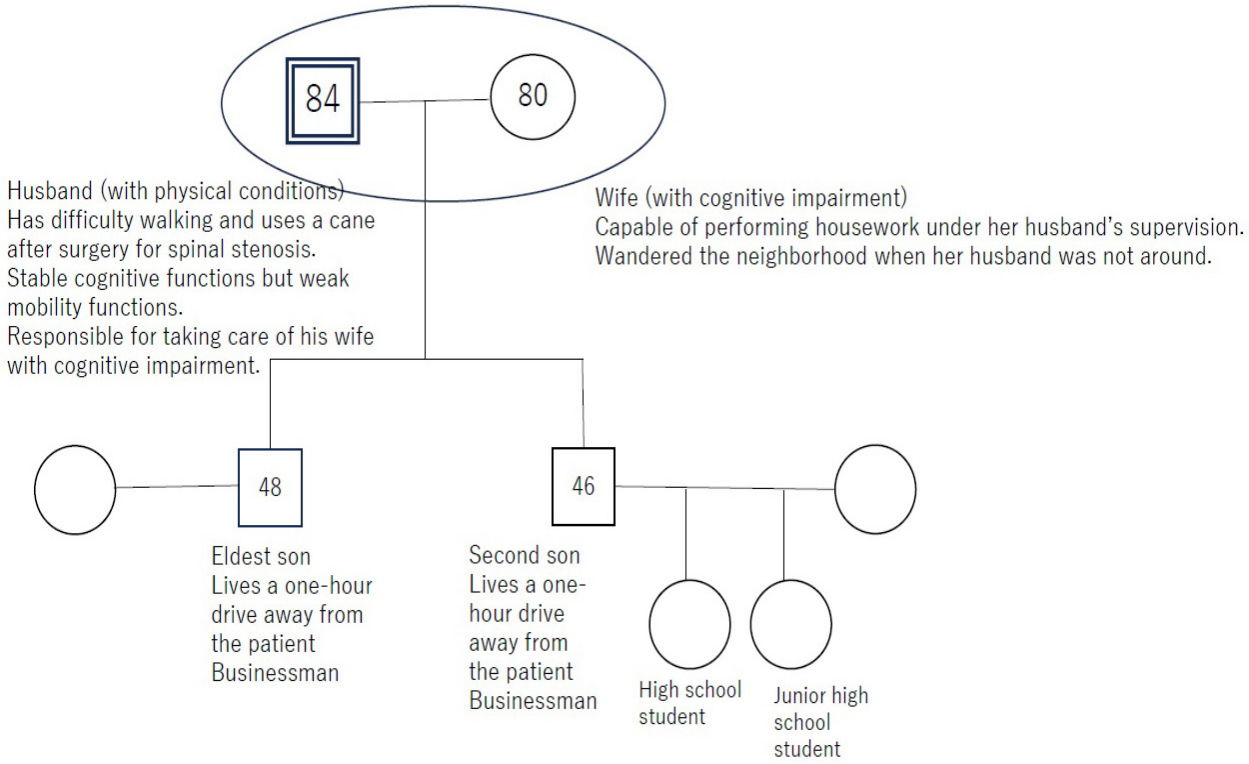

Figure 1: Genogram.

demanded early discharge because of his worries about his wife with cognitive impairment, leading to a conflict between the patient's and the family's desires.

Nursing practice

Situation summary

The medical team determined that the patient's hospitalization was necessary until a proper home-care environment was established to address the situation of his frequent loss of consciousness and tremendous burden of *rourou kaigo*, in which the older adult patient provided care for his wife with cognitive impairment. However, the ER chief nurse considered it undesirable to separate the couple again by the husband's hospitalization because the wife began to exhibit unstable behaviors, and the risk remained that she would wander again, looking for her husband. Furthermore, the patient would not allow himself to be hospitalized, due to worries about his wife's safety. Moreover, the patient and his wife exhibited a strong bond between them, overcoming similar challenges together by using public services such as a home-visiting nursing service. The chief nurse determined that the couple could continue living together at home, if a proper and improved home-care environment were established for them. Therefore, the ER chief nurse proposed to set up a home-care support team and made necessary adjustments with the medical team and the patient's eldest son, who both considered that the patient's hospitalization was the best option.

Family status assessment

Although the patient's movement was slow due to his spinal stenosis, he could perform ADLs for himself at his own pace. His wife experienced severe memory loss and was sometimes unable to remember how to operate home appliances due to her cognitive impairment. However, she could perform the housework under her husband's supervision. The couple both realized their physical and mental decline, but sustained themselves by helping each other and accepting social support. Their two sons lived a one-hour drive from the patient, leading their own lives, busy with occupational and parenting duties. They visited the patient couple's home on holidays to support them, exhibiting a strong emotional bond between family members. Their eldest son intended to respect the patient's wish and agree with the couple to live together at home, if a proper and improved home-care environment was established. Their second son helped the eldest son to support the couple. The patient and his wife accepted their family's and others' support, and the couple's anti-crisis resilience was relatively high. The family appeared to be managing itself well according to the couple's health conditions and social status.

Organizing medical team conference

The ER chief nurse set up a conference with the ER team on the day of the patient's admittance so that the relevant parties could exchange opinions from their own point of view to determine the best care setting for the patient and his family. The ER doctor and dermatologist reconfirmed the prognosis for healing the lower leg burn and the evaluations of the patient's systemic condition at admittance. Respecting the patient's wish for early discharge, they stated their assessment that living at home would be feasible if a proper home-care environment was established. The ER primary nurse indicated the necessity of conferences with home-visiting nurses and relevant parties, especially the local care managers. The nurse stated that sharing relevant information regarding specific care strategies, such as in-home treatment and emergency response protocols, was essential to minimize the patient's frequent emergency transports. In other

words, the primary nurse confirmed the overall assessment that the patient was capable of managing his health conditions and continuing to provide care for his wife with cognitive impairment, but the home-care team was apprehensive about an early discharge.

Joint conference to organize an optimal care setting for the patient and his family (Figure 2)

The ER chief nurse called for another joint conference the day after the patient's admittance, involving eight participants: the patient, his wife, and their eldest son, the ER doctor, the ER primary nurse, the care manager, and the home-visiting nurse. Various opinions were exchanged and information shared, with each party expressing their points of view in the conference to determine the best care setting for the patient and his family, as well as the home-care support system necessary to realize and maintain the care setting. The patient and his wife expressed hopes and anxieties about their future. The care manager suggested a strategy for utilizing necessary formal/informal resources both in the short and long terms for the patient and his family to live comfortably. The home-visiting nurse indicated that they could visit the patient's home a few days a week, though they understand the necessity of daily visits, and voiced concern regarding the possibility of another emergency transportation. The nurse also mentioned that discussing the matter with the eldest son was mandatory to prepare for the near future when the couple could become incapable of leading their current independent lifestyle. In response to this remark, the care manager suggested starting preparation to utilize municipal resources in addition to the current home-visiting care service, including using a day care center or introducing a helper service from the private sector. The patient and his wife were convinced that they could maintain the current lifestyle and receive community support, as they became able to imagine a home-care environment. The ER chief nurse confirmed that all relevant parties agreed with providing care at home and concluded the conference successfully from the medical team's exchange not only with the patient and his wife, but also with the home-visiting nurse to identify specific care contents necessary for the patient and his family. The patient was discharged the day after his admittance.

Discussions

The aging of society is progressing rapidly in Japan, and the number of households with older adult couples living alone is increasing. A substantial number of them are *rourou kaigo* families, in which the elderly care for the elderly, caring for each other's health conditions. It is a care style supported by the bond and compassion between family members. At the same time, caregivers and recipients are both old, and their physical and mental burdens are exceptionally high, posing a high risk of burnout for both caregivers and recipients. The role of community support systems is extremely significant in these circumstances.

The significant purpose of support practices for the *rourou kaigo* families, first and foremost, is to reduce the caregiver's physical and mental burdens by improving community support. The caregivers themselves often have to deal with their own issues, such as aging-derived physical function decline or chronic conditions of their own, making it impossible for them to be responsible for providing care 24/7. Therefore, the respite support for the caregivers is available publicly as a home-visiting care service or a day care service, allowing the caregivers to rest and reduce their physical and mental fatigue. Experts' advice and a helper technique training program are also available for in-home caregivers to comfortably continue their care provision. In this study, the husband who underwent surgery for spinal stenosis was responsible for the care of his wife, posing a substantial physical burden for him. Despite that, his emotional bond with his wife was so strong that he was probably unable to assess his own physical conditions objectively. Opportunities for the patient and his family to share details about the support provided by the medical team and municipality from each party's point of view can be effective in cases such as the one discussed here.

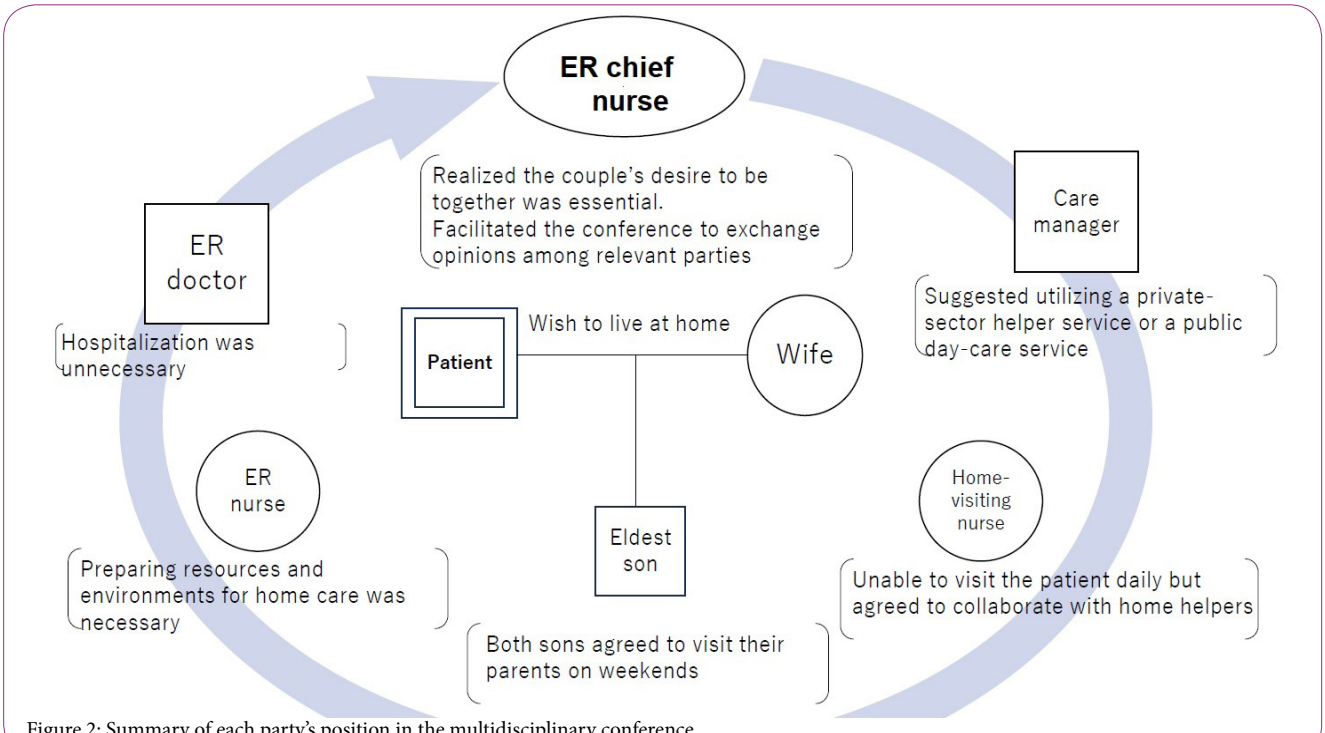

Figure 2: Summary of each party's position in the multidisciplinary conference

The second important purpose of the support practice is that the community support system is supposed to prevent the caregivers' social isolation. The *rourou kaigo* household members often go out less and less, and they become more socially isolated. The caregiver's isolation may develop into depression or lead to their own development/progression of cognitive impairment. Regular home visits based on the municipal services or community network and providing *rourou kaigo* families with social exchange opportunities with neighbors and volunteers are essential support practices for recipients to have a sense of security and hope for their future. The family members in this case, the patient's sons, visited their parents regularly on holidays despite their own busy schedules. In this sense, enhancing the supportive structure in the family is also a significant resource.

The third significant aspect of support practices is that community support is essential to sustain the recipient's lifestyle. In the *rourou kaigo* families, fundamental ADLs such as shopping for daily necessities, cleaning the house, and visiting the hospital often become challenging tasks. The *rourou kaigo* families can continue living in their homes longer in communities where relevant support services are sufficiently available, such as meal delivery service, shopping support service, and commuting service. The hospitalization or institutionalization of *rourou kaigo* family members can be prevented if a sufficient level of collaboration is established between medical staff and home-visiting care staff to provide a support system capable of a swift response when an abrupt health decline occurs. The caregiver in this study had diffERlties walking or performing physically demanding tasks due to his condition of spinal stenosis. Although his wife assisted him in performing ADLs, her condition of cognitive impairment prevented her from making necessary decisions to sustain their lifestyle. As such, combining several support resources, such as introducing a private-sector helper service to support the older couple's life, as seen in this case, is the key to sustaining their lifestyle.

At the same time, utmost attention must be taken for emergency response protocols. A certain guideline must be established for the *rourou kaigo* family members so that the caregiver or recipient can call for help immediately during emergencies, such as when the other member abruptly falls unconscious or begins to wander around the neighborhood due to cognitive impairment. In this case study, the patient's wife exhibited unstable behavior after the patient was taken to the hospital.

Introducing a safety confirmation system using a personal emergency response system, monitoring network, and relevant information and communication technologies is critical to provide safety for older adults. An additional system must be implemented to alert their children living far away.

As such, establishing a support system connecting medical and community services functions is "an external factor" in tackling the problems in rourou kaigo situations. A case of an older adult male patient who was frequently taken to the ER Center was discussed in this study, and revealed the presence of conflicts, even between medical professionals. The family members also expressed differences in their viewpoints regarding safety. Similar cases are often observed in Japan, where the number of *rourou kaigo* families is rising. Therefore, a conference where participants can assess the situation and exchange opinions based on each party's viewpoint and organized by a nurse who can supervise the matter comprehensively, such as an advanced practice nurse, is effective for reaching an agreement among relevant parties. As in this case study, the multidisciplinary conference played a significant role in organizing the support structure involving the patient, his family, the medical team, and the home-visiting support team.

Conclusion

Identifying and exchanging each party's point of view and conflicts in multidisciplinary conferences to establish understanding among the patient, his wife, his family, medical, and home-visiting support teams enabled participants to focus on the potential and available resources for the patient's family, leading to a successful coordination of a proper home-care environment. Positive interaction between the patient's family and support system led toward the establishment of a favorable home-care environment.

Competing Interests

The authors declare no competing interests relevant to this article.

References

1. Ministry of Health, Labour and Welfare (MHLW). Summary Report of Comprehensive Survey of Living Conditions 2024. https://www.mhlw.go.jp/toukei/saikin/hw/k-tyosa/k-tyosa24/index.html
2. MHLW. Summary Report of Comprehensive Survey of Living Conditions 2022. https://www.mhlw.go.jp/toukei/saikin/hw/k-tyosa/k-tyosa22/index.html.

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