

OVERVIEW OF HERALTH CARE RESPONSIBILITY IN ELDERLY HOMES

By

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Abstract

A nursing elderly home or hostel in an international or governmental nonprofit organization that offers older adults short-term, low-cost courses, housing, and meals, usually on selected good areas. The term elder hostel comes from Elderhostel, the original name of a non-profit organization which has since changed its name to Road Scholar. Their primary responsibility is 24 hours a day to help the elderly maintain their quality of life by administering medications, developing treatment plans, and monitoring vital sign.

Nevertheless, many of the Arab traditional social values are still present strongly in most the family correlation, cohesion, solidarity which protects the parents during their late-life; there are differences in the correlation in different countries according to their social and economic development. As well as some differences between countryside and town within the same country, where it is found that the family relationships are stronger in the countryside. The Holy Quran wrote regarding the parents (If one or both of them reach old age with you, then do not say words of irritation to them nor scold them but speak to them with respect).

Key words: Elders, Nursing care home, Overview.

Introduction

The world is facing an unexpected elder's growth, requiring long-term nursing home services where they live as safely as possible as they can no longer perform everyday activities on their own (Katz, 2011). On average, nursing home residents stay in a long-term facility for <2 years, 25% of Americans died there, within six months (Kelly *et al*, 2010). Globally, social isolation and loneliness affect about half of the elders have a negative impact on their physical and mental health (Landeiro *et al*, 2017). There were 1.5 million residents in nursing homes/skilled nursing facilities of whom 919,000 in assisted living (Harris *et al*, 2019). Elders discharged from a hospital to skilled nursing facilities (SNFs) experience high rates of unplanned hospital readmission, indicating opportunity for improvement in transitional care (Krol *et al*, 2019). By 2030, 1/6 world people will be aged 60 years or over. By 2050, world's populations of people aged 60 years and older will double (2.1 billion). Persons aged 80 years or more is expected to triple

between 2020 and 2050 to 426 million. The distribution shift of a country's population to elders began in high-income countries (Japanese population (30%) were <60 years), it is now low- and middle-income countries show a greatest change (WHO, 2022).

But, in Arab and Middle Eastern Countries, family is the solid foundation of population growth with an important-role in the humans' development (Abdelmoneium and Alharahsheh, 2016). In Egypt, Head of National Population Council reported that the population is expected to be between 142 & 157 million by the year 2050. For everyone to lead an independent and dignified life at any age, communities benefit from demographic dividend, national policies and systems via all sectors must address wellbeing and rights across human life (Egypt profile, 2021). The Egyptian elders need well established nursing care home, as traditionally family provided, but this attitude differed in bigger cities (Boggatz *et al*, 2009).

Significance: Every country is experiencing growth in size and proportion of elders.

They are very vulnerable and access health care frequently due to their age related changes. Aging population is increasingly serious due to health-problems such as increased independence, self-reliance loss and diminished physical and mental capacity. This article aimed to explore medical and nursing care responsibility in elderly homes by 1- Review the current situation of older adult, 2- Gave a comprehensive review of common health problems affecting older adults and measures of assessment and care, 3- Recognize level of nursing education and knowledge necessary to promote health and wellbeing of older adults. 4- All selected studies were evaluated and screened based on title, and full text related to the objectives. The older people” defined as 60 years of age and more” was 6.1% of total population according to the last Egyptian census in 1996, 7.2% in 2006 to 8.9% in 2016 and will be 10.9% in 2026. The domains and suggested

items for comprehensive geriatric assessment include physical, mental and psychological health, functioning, social status and environment. Pain in advanced dementia scale ranged from 0-10 points, with scores interpretation: 1-3= mild pain; 4-6= moderate pain; 7-10=severe pain, based on a standard 0-10 scale of pain

There were six stages of pressure-induced skin and soft tissue injuries tool as a standard scales to identify stage of skin ulcers. Assessment of decision-making capacity of them by some sample questions for every decision marked ability as understanding, choice expressing, appreciation and reasoning. Frequency distribution of sample as to knowledge levels on elderly care (28 items with one right answer) in an ascending order, <70% gave incorrect answers.

Results

Details were shown in tables (1, 2, 3, 4, & 5)

Table 1: Expected Egyptian demographic data (Gadallah, 2006).

Year	Total life population	Elders	Male at birth	Male at 60+	Female at birth	Female at 60+
1960	26 (million)	6.0%	51.6	-	53.8	-
1976	36.6 (million)	6.2%	52.7	-	57.7	-
1986	48.3 (million)	5.9%	60.5	14.3	63.5	15.7
1996	59.4 (million)	6.1%	65.1	15.3	69.0	17.3
2001	64.2 (million)	6.5%	67.1	-	71.5	-
2006	70 (million)	7.2%	69.2	16.8	73.5	19.1
2016	81.3 (million)	8.9%	72.5	18.1	77.2	20.9
2026	93 (million)	10.9%	74.7	19.3	79.4	22.6

Table 2: Staging of pressure-induced skin and soft tissue injuries (AfterThe National Pressure Ulcer Advisory Panel)

Stage	Description
1	Skin intact but with non-blanchable redness for >1 hour after relief of pressure.
2	Blister or other break in the dermis with partial thickness loss of dermis, with or without infection.
3	Full thickness tissue loss. Subcutaneous fat may be visible; destruction extends into muscle with or without infection. Undermining and tunneling may be present.
4	Full thickness skin loss with bone, tendon, or joint, involvement with or without infection. Often with undermining and tunneling.
Unshakeable	Full thickness tissue loss in which ulcer base covered by slough and/or eschar in the wound bed.
Deep tissue injury?	Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying tissue from pressure and/or shear.

Table 3: Pain Assessment in Advanced Dementia scale (PAINAD)

Items*	0	1	2	Score
Breathing vocalization independent	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing, hyperventilation long period, Cheyne stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Bad speech without or disapproved quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial expression	Smile or in-expressive	Sad. Frightened. Frown	Facial grimacing.	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure.	

Table 4: Decision-making abilities, their definitions, and questions to assess them

Decision	Definition	Sample questions
Understanding	Ability to state diagnosis, risks & treatment or procedure, indications & care options.	After disclosing a piece of information, pause and ask patient: Can you tell me in your own words what I just said about (fill in topic disclosed)?
Choice expressing	Ability to state a decision.	What would you choose?
Appreciation	Ability to explain how information applies to oneself	To assess diagnosis: Can you tell me in your own words what you see as your medical problem? To assess benefit: Regardless of what your choice is, do you think that it is possible the medication can benefit you? To assess risk: Regardless of what your choice is, do you think it is possible the medication can harm you?
Reasoning	Ability to compare information and infer consequences of choices.	To assess comparative reason: How is X better than Y? To assess consequential reason: How can X affect your daily activities?

Table 5: Frequency distribution of samples according to Knowledge about elderly care (28 questions)

Knowledge about care of elderly people.	Yes	%
Score indicating mild depression for elders according to geriatric depression scale is (7±3).	20	6.3%
Orientation, memory, attention, language, recall tested by use of Folstien mini-mental status instrument.	37	11.63
We age because of wear and tear of important organs by continuous functioning.	38	11.9%
Falling among elders can be prevented by balance exercises	39	12.2%
Increase incidence of orthostatic hypotension among elders.	45	14.1%
Basal metabolic rate declined with aging due to loss of lean muscles.	48	15.0%
Health needs and physical examination of elderly are different from other age group population.	58	18.1%
Balance and risk for falls assessed in elderly by Get-up and go test instrument	55	17.2%
Recommended fluid intake for elderly people is 1500-200ml/day unless contraindicated.	60	18.9%
Elders with diabetes, heart disease, thyroid, and hypertension more at risk for herbs adverse effects.	76	23.8%
Person is considered elderly above the age of 65years.	78	24.4%
Fish oil and Vitamin E are two basic nutrients that preventing progress of Alzheimer.	79	24.7%
Average recommended calories for elderly people is 25-28cal/kg/day 8	80	25.0%
Nursing concentrated on health promotion primarily focused on a sense of control over health problem	87	27.2%
Care given with altered sensory perception by reducing noise, speak louder and slowly without verbal cues if needed	94	29.3%
Urinary continence can be regained by performing Kegel exercises and fixing a toileting schedule	97	30.3%
Encourage elders to use sensory aids and enhance extra time for communication with elderly.	100	31.3%
When checking blood pressure, systolic one rises with aging because of loss of arteries elasticity.	109	34.1%
Mal-nutrition, bed sores, and poor hygiene are signs of elderly neglect	112	35.0
Short term memory and attention span declined with aging.	115	35.3
Walking 30 minutes three days per week is the most recommended exercise.	118	36.9
Osteoporosis prevented by adequate calcium intake, regular exercises, estrogen replaced therapy for women.	122	38.1
Teach hypertensive elder on diuretics to encourage fluid intake, potassium rich food and to monitor dehydration.	128	40.0%
Nurse must focus on non-verbal communication skills with those suffering from hearing deficits.	135	42.2%
Dehydration can be prevented by assessing skin turgor, mucous membrane and urine output.	143	44.7%
Adequate respiratory function can be maintained by instructing client deep breathing exercises	150	46.9%
Promoting sleep pattern by reducing daily, napping, caffeinated beverages, and relaxation techniques	152	47.5%
Anatomical areas often affected by development of pressure sores; iliac crest, & ischia tuberosity.	154	48.1%

Review and Discussion

Globally, older people are more often have complex care needs due to old age and multiple chronic conditions, so they are described as requiring comprehensive fundamental nursing care, related to nutrition, mobility, elimination, personal hygiene...etc. attending to such needs lies well within the remit of nursing (Nordaunet *et al*, 2023).

Problem: There is a growing appreciation of long-term care residents' needs for palliative care services, especially for those with advanced, incurable, and/or chronic diseases, including symptom management, care of dying resident, support for family caregivers, assistance with decision making as to

diagnosis, and plans for if an acute illness were to happen (i.e., wishes regarding transfer to an acute care facility). Older ones have high risk for functional impairments with inability to perform ordinary activities of daily living or related to house hold management (Gill *et al*, 2009). Thus, a country with increases in the older population has to be prepared for the epidemiologic transition from infectious diseases of the young population to the chronic diseases of the old ones. Health services and resources have to be directed to medical care, home and institutional care. Egypt has a diverse health system with numerous public and private healthcare providers (Sweed and Maamoun, 2021).

In a national survey of bereaved family caregivers of nursing home residents, the following data were reported (Teno *et al*, 2004): a- Between 32% & 24% of loved ones that had experienced either pain or dyspnea, respectively, didn't receive good help, b- About 60% reported receiving inadequate emotional support during their loved ones' terminal illnesses, & c- Only 42% their loved one's quality of life in the nursing home as excellent, with lowest rating of all health care settings versus, 71% gave an excellent rating to care delivered with hospice services.

Patient characteristics, care needs, & clinical course: Most nursing home residents are elders with significant physical and cognitive impairments. National Nursing Home survey, nursing home population within USA was characterized as follows (Jones *et al*, 2009): a- About 50% were >age 85, b- More than one-half were either totally dependent or needed extensive assistance in daily activities & c- Half of residents received nine or more routine medications. Nursing homes' residents may have one or more chronic diseases across their life expectancy and/or cause symptoms that add to burden, such as cancer, congestive heart failure, chronic lung disease, diabetes, arthritis or infectious disease (Furman *et al*, 2019) or skin dermatitis by insects bites (Morsy, 2012).

There was a complexity of health issues in elders, nurse and nurse researchers need to pursue the best ways to address their needs, investigate and disseminate technology-based assessments, provide culturally appropriate interventions to promote independence, prevent chronic conditions, and enhance health equality (Thiamwong 2022). Comprehensive assessment involves looking not only at disease states as a standard medical assessment would do, or at functional ability as a standard rehabilitation assessment might do, but at domains range (Ellis *et al*, 2017). By assessing each health domain, a comprehensive assessment was done and full biopsychosocial nature of personal's problems were identified supported by using standard

scales and tools, or formal assessment schemes tools (Spirgiene and Brent, 2018). Focused attention & cognitive processing speed were assessed with the Trail Making Test A (TMT-A), handgrip strength was used as a measure of sarcopenia, mobility assessed with "Timed Up-and-Go" test, and independence in primary activities of daily living by Barthel Index. Of 150 eligible male patients, 83 with mean age 87years, 25% had average 6 diagnoses and used daily medications, 61 (75%) with grip strength sarcopenia, 27 (33%) impaired mobility, & 69 (83%) an impaired TMT-A score (Næss *et al*, 2017).

Dementia as a primary problem in nursing home residents, though many persons were admitted to long-term care facilities due to the effects of cognitive impairment, prevalence of dementia among them in long-term care facilities is uncertain (Livingston *et al*, 2020). About 2/3 of individuals in assisted living carried a diagnosis of dementia (Magaziner *et al*, 2000). The estimated dementia prevalence among nursing home residents ranged from 32% in the 2004 to 50% of persons admitted (Rosenblatt *et al*, 2004). But, caring for those with dementia may perhaps the most challenging in terms of given high quality palliative care as cognitive impairment complicates their ability to report symptoms and ultimately required involvement of surrogate decision makers.

Dementia is an incurable and progressive condition, although this may not be recognized by family caregivers and nursing home staff. During the years they live in a nursing home, they frequently experience pneumonia, febrile episodes, and eating problems as dementia became more advanced (Mitchell *et al*, 2009). Dementia persons experience behavioral changes that can be challenging for long-term care staff to address, including resistance to care, agitation & wandering (Cerejeira *et al*, 2012). Behaviors occurred independently or developed as a manifestation of a symptom or medical condition such as pain and/or infection (Dantzer and Kelley, 2007). Sickness is a response to infection, as

fear normally in predator's face (Hart, 1988). Sickness behavior described drastic changes in subjective experience and behavior occurred in physically patients and animals, is an expression of a previously unrecognized motivational state (Dantzer *et al*, 2008).

Estimating prognosis importance: Though nursing home residents have multiple physical, cognitive, and functional comorbidities, health professionals should attempt to estimate residents' prognoses because this may influence decision making, including whether the burdens of a potential decision (e.g., acute illness hospitalization) outweigh risks and whether a resident met hospice eligibility criteria (Porock *et al*, 2010). Prognostic indices estimated nursing home residents' 6month all-cause mortality risk, and one-year mortality risk of both newly admitted residents or who have lived in a nursing home for more than a year (Flacker and Kiely, 2003). Longitudinal intake of nursing home patient in nursing homes, structured interviews done at initial intake and then at periodic intervals were a must to ensure symptoms were addressed and care goals were met (Glaudemans *et al*, 2018).

New nursing home patients: For all newly admitted patients to a nursing home, a comprehensive evaluation is a must (Leland *et al*, 2012). This must include: 1- Symptom assessment, with especial focus on cognition, pain, and constipation, 2- Medication review, including patients questions (and/or their caregivers) as to the effectiveness and side effects that being important as polypharmacy issues may be an issue in the nursing home, 3- Review of existing advance care planning documents, for those without completed advance care planning, assistance is a must to give a completing this paperwork. For patients who didn't designate a surrogate decision maker, clinicians should directly inquire about who wanted to help make health care decisions that help in the health care proxy selection, and 4- Discussing patient's care goals, recognizing complexity of residents admitted to long-term care facilities,

health professionals must seek to understand their primary goals and express a commitment to promoting consistency between residents' care in facility and his /her treatment preferences. If multiple goals are identified, patients and families must be asked about prioritization of the stated goals, as all residents must have symptoms assessed and treated as part of their care plan, some residents' may hold an exclusive focus on comfort without seeking to extend life or achieve functional gains as the main priority care goal (Dunham and MacInnes, 2018). Goals must include life prolongation independent on baseline function, promotion of functional and cognitive rehabilitation, and/or enhancing resident's comfort (Froggat *et al*, 2020).

Established nursing home patients: Periodic assessments are required for nursing homes' patients (Clauser and Fries, 1992). This is particularly important for patients with progressively deteriorating diseases, including advanced dementia and advanced malignancies. This must include: 1- Periodic symptom assessments that may require sources other than patient, and his/her caregiver, including that of long-term care staff and family caregivers, particularly true for those with dementia. 2- Semiannual review of medications, if long-term care residents experience functional and cognitive decline, medications that were beneficial may no longer be indicated and their continued use may pose side effect risks. Also, consider discontinuing medications based on the resident's care goals, prognosis, and other difficulties such as swallowing problems and perceived pill burden. 3- Annual review of advance care directives, communicating about such directives helps ensure that care plans remain appropriate and enable changes to be made in response to changes in residents' condition and care goals. 4- Assess condition and any anticipated changes in their condition, this communication relates to discussion of residents' care goals and advance directives and may inform decisions as to tube feeding, hospitalized, and utilization of hospice ser-

vices. For residents with dementia, this may include when families may expect to notice behavioral changes, functional decline, feeding problems, and increased risk of infections. Consider estimating resident's prognosis to this communication.

Specific symptoms: 1- Pain: All the USA nursing homes that received federal funds must periodically report the residents' percentage moderate to severe pain using the minimum Data Set (Chu *et al*, 2004). Untreated pain is a particular concern for patients in palliative care, and it appears to be an important issue for nursing home residents, especially those with cancer (Hanlon *et al*, 2010): 1- Estimates are that up to 37% of nursing home residents report pain as excruciating in less than 5%. Among residents who died there and assisted living facilities, approximately one-half were reportedly in pain during the last month of life (Caprio *et al*, 2008). 2- Also, more than 65% of newly admitted Medicare eligible nursing home residents with cancer had pain, 28% daily (Pimentel *et al*, 2015). Adequate analgesia was significantly negatively associated with age 85 & more (adjusted odds ratio [aOR] 0.67, 95% CI 0.550-0.81), cognitive impairment (aOR 0.71, 95% CI 0.61-0.82), the presence of feeding tube (aOR 0.77, 95% CI 0.60-0.99), and use of restraints (aOR 0.50, 95% CI 0.31-0.82). For patients in the nursing home, pain may be related to osteoarthritis, neuropathy, or due to chronic illness itself, especially cancer (Giovannini *et al*, 2021). As with patients receiving palliative care in other settings, it is important that attention be made to ensure adequate pain assessment and management. Assessment must include the consideration of pain onset, location, duration, quality, severity, and both alleviating and exacerbating factors. A review of past management strategies and effectiveness must be completed. Pain management included non-medication strategies (e.g., mass, age, positioning, and music), non-opioid

medications including acetaminophen, anti-inflammatory, and neuropathic medications, and topical gels and patches. While there can be concern that use of opioid medications in older adults may be associated with delirium and other undesirable side effects, age alone must not be a contradiction to opioid use for residents in long-term care settings. Residents with moderate to severe pain or discomfort, and didn't respond to others must be treated with opioids via geriatrics prescribing principle of start low and go slow may be used (WHO, 2019). But, older adults may require and tolerate same opioid dose as a younger one. The residents' renal and hepatic function must also be in mind when choosing and increasing opioid doses. Interventional approaches such as nerve blocks and radiation treatments may also be pursued (Chau *et al*, 2008).

Assessing pain in patients with impaired cognitive function: The nursing home residents with dementia are less likely to receive pain medications than those with normal cognitive function (Reynolds *et al*, 2008). Strategies to assess patients' pain with severe cognitive impairment include (Shega *et al*, 2007): 1- Grimacing or guarding with movement, 2- Agitation unrelated to movement, 3- New or worsening sleep disturbance, & 4- Appetite loss. For health care workers in nursing home, presence of dementia can result in challenges to pain assessment. Also, watching for behavioral cues that may suggest a patient is in pain, two nonverbal pain behavior scales were tested in long-term care facilities, and validated to use easily Checklist for non-verbal pain indicators (CNPI) involves observations of six behaviors with movement and at rest that can be associated with pain, including facial grimaces (Feld, 2000). The pain assessment in advanced dementia (PAINAD) tool contains five items each scored 0 to 2 to yield a total score of 0 to 10 to rate pain severity. 2- No pain symptoms, as limited data were on patients' symptom experiences in palliative care that lived in long-term care facilities: a- Eating prob-

lems with increased symptoms affecting intake must be differentially diagnosed (Lapid *et al*, 2010). The symptoms can include dental problems (lack of teeth, ill-fitting dentures, and gum disease), lack of appetite, regurgitation, dysphagia, and xerostomia associated with medications and affecting salivary gland function. Residents with dementia and/or cerebrovascular accidents can develop oral apraxia, including having difficulty with utensil use and other atypical behaviors (e.g., pocketing food). About 50% of patients dying in nursing homes experience dyspnea in assessment periods ranged from last week to final life three months. Dyspnea prevalence (10%) among dementia individuals, but difference may be associated in part to assessment challenges due to cognitive impairment (Mitchell *et al*, 2004). As to constipation about one-third have constipation at life end (Gonzales and Widera, 2011), but less than 10% of dying ones experience nausea (Rodriguez *et al*, 2010). About 10% of nursing home residents have a pressure ulcer that cause more complicated medical problems such as pain, a superimposed cellulitis, osteomyelitis, and sepsis. Among them, stage II ulcers (Tab. 2). Development of pressure ulcers among nursing home residents is a quality of care measure by the Centers of Medicare Services (CMS). Therefore, nursing homes are obligated to report such data that are publicly available for each facility. Delirium among patients admitted to a nursing home after hospitalization for an acute illness, 41% were assessed to have delirium (Marcantonio *et al*, 2010). For dementia patients, delirium can complicate any acute change in condition, as injuries and infections. At life end cumulative delirium was up to 85% (Casarett and Inouye, 2001)

Weight loss: Weight loss in this context is likely multi-factorial due to difficulties with oral intake, gastrointestinal distress, and deconditioning. However, while residents with weight loss may be asymptomatic, especially if expected as part of their dementia progression, nutritional decline can be distressing

to family and staff caregivers.

Cleanliness: As residents' functional status declines and death approaches, the ability to keep the patient clean becomes a more prevalent issue for the staff, who reported that more than 90% of nursing home and 70% of assisting living residents had problems with cleanliness, included issues related to skin and oral care, as well as care to manage incontinence (Hanson *et al*, 2008).

Polypharmacy: While polypharmacy itself may not be considered a symptom, the volume of medications patients take on a daily or routine basis may adversely affect their appetite and contribute to nausea and constipation. A careful medication review should occur at the admission time to a long-term care facility, with any significant change in health status, and as individuals are identified as entering an advanced or life-limiting stage of any incurable illness. In particular, <one-half of nursing home residents with advanced dementia received medications of questionable benefit, including cholinesterase inhibitors, meantime, and lipid-lowering agents (Tjia *et al*, 2014). Discontinuing medications didn't compromise outcomes, but may be associated with better quality of life. In a randomized trial conducted in patients with an estimated life expectancy of 1 to 12 months (22% with dementia), there was no increase in mortality 60 days after statin therapy was discontinued, and they experienced better quality of life (Kutner *et al*, 2015).

Communication among nursing home residents, their caregivers, clinicians, and nursing home staff is critical to meeting residents' palliative care needs. However, effective communication can be hindered by several factors, which can also impede the formation of a trusting relationship that included: 1- Lack of visitation by health care providers as many physicians, nurse practitioners, and physician assistants responsible for the care of nursing home patients and for writing orders make infrequent visits to the institution, spent less than 2 hours a week providing care to residents (Katz *et al*, 1997). Infrequent

nursing home visits can negatively impact the clinician's ability to develop collaborative care plans with nursing home staff and with the residents and their families. 2- Lack of visitation by family caregivers, especially if they live at a distance or have other responsibilities. 3- Nursing home staff tends to suffer from a high rate of job turnover, which in some facilities was greater than 100% annually reflecting in issues between staff and caregivers. In a study of residents who died in long-term care, their family caregivers and facility staff differed on residents' prognosis and symptom burden (Williams *et al*, 2012). 4- Staff report received insufficient education and training on given palliative care (Zimmerman *et al*, 2003). In context of these factors, patients and their caregivers want contact with their clinicians demonstrated in a national survey of Bereaved caregivers whose family members died while in a nursing home (Kaasalainen *et al*, 2007). 5- About one-half of bereaved caregivers felt they were not told what to expect during the dying process nor did they recall being a part of any conversation with the clinician about the residents' treatment preferences (Biola *et al*, 2007). For advanced dementia patients, families' identify lack of communication with clinicians as a source of stress (Givens *et al*, 2012). Some data indicated that increased clinician presence can improve familial certainty that treatments being performed for their loved ones are appropriate (Helton *et al*, 2011). Since involvement of nurse practitioners in caring for nursing home residents with dementia was associated with high family satisfaction, expanded collaborations between the clinicians and nurse practitioners enhanced communication with nursing home staff, residents, and their families (Liu *et al*, 2012).

Decision making: Patients in nursing homes must be included in any and all decision making as long as they have decisional capacity (Tab. 3), those without decisional capacity (with advanced dementia), these decisions fall on surrogate the decision makers

in collaboration with the responsible clinician. Among the most frequent decisions faced by the surrogate decision makers for residents with dementia involve establishment of goals of care, issues related to feeding, and treatment of medical issues, including infections and pain (Givens *et al*, 2009).

Care communication goals: For long-term care ones, it may be useful to prioritize their most important goals as those that prolong life, promote function, or maximize comfort. Other goals that residents might identify include achieving life goals, such as attending an important family event, completing unfinished business, achieving peace with God, and allowing support for their families and caregivers (Kaldjian *et al*, 2008). Structuring discussion around the primary goal of care may not only improve communication, but also aid in subsequent decision making for long-term care residents. A study showed prioritization among these goals among caregivers was feasible (Gillick *et al*, 1999). For the residents and families able to articulate a primary or exclusive care goal, the clinician can then translate this goal into specific treatment recommendations, which can be accepted or rejected. This communication approach may lessen burdens of decision making experienced by residents and families.

Use of videos proposed as a mechanism to promote resident and family understanding of goals of care and decision making options: 1- In a randomized controlled trial, older adults who watched a six-minute goal of care video on admission to a nursing home were more likely to identify comfort as their primary goal compared with residents who received a verbal narrative. 2- Older adults exposed to a "goals of care" video related to the individuals' care with advanced dementia also chose comfort as their preferred goal more often than for exposed to a verbal care goals explanation (Vollandes *et al*, 2012). 3- A 20 minute goals of the care video decision aid about treatment options in advanced dementia, designed to support discussions during the nursing home care planning process,

was effective in enhancing agreement on goals, increased the palliative care content of treatment plans, and reduced hospital transfers (Hanson *et al*, 2017). Some families can identify different goals altogether or express multiple goals as having equal importance, but communicating about goals may be easier than asking for specific treatment decisions that family members may find stressful and burdensome (Gjerberg *et al*, 2017).

Decisions as to nutrition & hydration: Nutritional status and the occurrence of weight loss are topics of concern among nursing home residents. Weight loss may threaten residents' self-identity. Also, both residents and their families associate nutrition with life and its absence with starvation. The Centers of Medicare Services (CMS) reports the percentage of residents who lose too much weight (defined as >5% loss of body weight in a month) as a quality measure.

Role of artificial nutrition and hydration: As with any treatment decision, communication regarding artificial nutrition and hydration for long-term care residents must focus on the risks and treatment benefits, whether the decision supports the resident's care goals. Discussions as to use a gastrostomy tube for artificial nutrition and hydration occur commonly in long-term care. Other decisions include fluids use given intravenously or subcutaneously (hypodermoclysis). Total parenteral nutrition was rarely used in long-term care facilities due to logistical and financial barriers. For some residents, gastrostomy tube use is consistent with their care goals and has an acceptable risk/benefit consideration (Carey *et al*, 2006). These include individuals in whom artificial nutrition and hydration permits disease-directed treatment (as patients with a head and neck or newly diagnosed abdominal or pelvic malignancy) and others in whom recovery of swallowing function is an anticipated outcome (as patients recovering from a cerebrovascular accident). For others, use of a gastrostomy tube supports the goal of life prolongation and/or promoting function, including nursing home

residents in a persistent vegetative or those with a progressive neurologic conditions (as amyotrophic lateral sclerosis).

Among patients with advanced dementia in nursing homes, about one-third have feeding tubes, although there are few data to suggest it improves survival (Mitchell *et al*, 2003) or decreases the incidence of other outcomes such as pneumonia, weight loss, and pressure ulcers. Potential burdens associated with gastrostomy tube use include wound infections or restraints to prevent residents from removing tube, emergency room visits and hospitalizations to replace tubes removed or displaced and residents' pleasure may have from oral intake with tube feeding and hydration. Of 190,000 patients, 34% with advanced cognitive impairment had a feeding tube compared to those without, these patients were more likely to be of younger age, non-white race, male, divorced, and had no advance directives with recent decline in functional status (Teno *et al*, 2012). Also, many family caregivers report either no or minimal communication with clinicians as to decision for their loved one to receive a feeding tube (Teno *et al*, 2011). Despite these results, there are organizationally related factors associated with using feeding tubes, including greater use in for profit, urban located, and larger (>100 bed) nursing homes (Finucane *et al*, 1999).

Discussions of artificial nutrition and/or hydration in for patients undergoing palliative care must include the following information: 1- Lack of a known benefit from artificial nutrition and hydration in patients approaching the end of life, including responding to issues related to hydration and starvation, which may be raised by the patient and/or his or her family. 2- Risks associated with placement and maintenance of the feeding tube itself, including infections, aspiration, and potentially, the requirement for restraints if patients are physically unstable or violent (Gillick, 2000). 3- Alternatives to tube feeds or other artificial nutrition systems that were more aligned with their loved

ones' condition and care goals. For patients who were able to swallow, but low quality evidence to support the use of appetite stimulants, assisted feeding, and modified foods (Harwood, 2014). A randomized controlled trial showed that family caregivers who received a decision aid felt less conflicted but more likely to discuss feeding options with a health care provider (Hanson *et al*, 2011). Also, surrogate decision makers who used a tube feeding decision aid had less conflict and increased knowledge about decision of ultimately chosen (Mitchell *et al*, 2001).

Infectious complications caring in long-term care residents frequently have febrile episodes or can develop infections without fever, including pneumonia and urinary tract infections. Deciding whether, where & how to treat infections need discussion among clinicians, residents, and their family without acute care hospitalization (Dosa, 2005).

Significance of evidence-based on nursing practices in interventions and treating respiratory disorders was underscored in this SLR-MA, nurses can successfully promote health and empower elders to take charge of their well-being by education, support, and psychological assistance, guiding to manage their health effectively. Besides, integrating family involvement is essential to promoting self-care in respiratory chronic disorders (Ribeiro *et al*, 2023). Patients with pneumonia and a respiratory rate <40 were effectively treated in the nursing home, associated with lower costs and improved morbidity and mortality rates compared to acute care hospitalization. After consideration of their care goals and prognosis, residents and their families may decide with their clinicians to seek hospital evaluation and treatment for acute infections, initially provide management in nursing home while transferring to the hospital if a resident's condition worsens, or focus care exclusively on their symptoms without diagnosing the cause of a febrile episode. Independent of their primary care goal, patients with a systemic infection in the context of advanced

dementia have a poor prognosis. While families and clinicians may consider infections to be reversible, the development of serious infections among patients advanced dementia usually shows that death was approaching, regardless of whether antibiotics are administered. In patients diagnosed with pneumonia, the 10day and six-month mortality rates were 50% & 74%, respectively ((WHO, 2023). Antimicrobial treatment of urinary tract infections in nursing home residents with advanced dementia didn't improve survival (Dufour *et al*, 2015). While hydration and antibiotic use may prolong short-term survival, this benefit may only be measured in days among most residents with advanced dementia (Givens *et al*, 2010) and may also increase discomfort (Szafara *et al*, 2012). So, for residents with comfort as a primary goal that subsequently develop a systemic infection (pneumonia), care must focus on managing symptoms (as fever, congestion, dyspnea, and delirium) rather than infection aggressive treatment. Their families must be informed that use of antibiotics for managing infections in residents with advanced dementia will likely not promote comfort and may prolong the dying process (Lester *et al*, 2016).

Initiatives to improve palliative care in the long-term settings: There was limited availability of palliative care programs in United States nursing homes, and significant underutilization in those facilities with programs (Kovach *et al*, 1996). Little data were about the interventions implementation that improved the palliative care quality in long-term care settings (Casarett *et al*, 2005), but chief among them is ensuring greater access to hospice services (Hanson *et al*, 2005). In the United States, this already occurred with hospice enrollment increasing from 28 to 40% among nursing home residents between 2004 and 2009 (Hall *et al*, 2011). A similar increase in hospice enrollment was among dementia patients. The benefit of hospice services is clarified in the following: 1- In 786,328 Medicare fee-for Service benefi-

arians older than age 67 who died while they were nursing home residents in 2004 and 2009, the increase in hospice use from 28 to 40% over this five year period was associated with significant decreases in rates of hospital transfers, feeding tube use, and a lower rate of ICU use in the 30 days before death (Gozalo *et al*, 2015). But, expansion of hospice use was also associated with a mean net increase in Medicare expenditures, reflecting greater additional spending on hospice care after adjusting for decreased spending on hospital and other care. But, others note that Medicare spending on hospice care for nursing home patients grew 70% between 2005 and 2009 (Unroe *et al*, 2015). 2- All nursing home residents in one state who received hospice care prior to death, their families believed that hospice improved their loved ones' symptom management and attention to their emotional needs (Miller *et al*, 2010). 3- For residents with advanced dementia in nursing homes, those received hospice services were more likely to receive scheduled opioid medications for pain, symptomatic treatments for dyspnea, & overall had fewer unmet needs at life end compared with residents dying without hospice care (Baer and Hanson, 2000). There were many barriers to hospice use in long-term care settings including: 1- Imprecise ability of clinicians prognoses' in dementia residents and other terminal, non-cancer diagnoses (Kiely *et al*, 2010). 2- Negative associations between hospice and death held by residents, families, and long-term care staff. 3- Lack of coverage for the room and board costs in long-term care facilities, but there is a Medicare benefit that covers skilled nursing facility admissions, it is specific for rehabilitative services associated with acute care hospitalizations and ends when patient's rehabilitation progress plateaus or if the patient experiences an acute decline that prevents him/her from receiving therapy services. Many didn't achieve the rehabilitation goals and would likely benefit from receiving palliative care and hospice service (Aragon *et al*,

2012) experienced a decline or plateau, prompt a transfer to hospital for stabilization and/or interventions. Others may request a transfer to home to die, but others may attempt to return home to avoid substantial daily nursing home costs (Carlson *et al*, 2011). Although hospice services represent a potential major source of palliative care in nursing homes, one-half of individuals in nursing home hospice have enrollments of 22 days or less given many barriers (Hamel, 2015). To expand access to palliative care, alternative models, such as palliative care consultations by external providers with palliative care expertise and/or specialty consultations were explored (Miller *et al*, 2016). But, to ensure the access to hospice, all patients must be encouraged to complete advance care planning. For long-term care residents, one example is the physician orders for life-sustaining treatment (POLST) document, which provides a portable, valid order set for patients that can be used across the continuity of possible care settings, including the home, the ambulance, and all institutional settings (Hickman *et al*, 2010). Initially developed and implemented in Oregon, this order enables health care professionals and patients or their surrogate decision makers to designate a primary care goal and make specific decisions regarding cardiopulmonary resuscitation, antibiotics, tube feeding, and artificial hydration. The use of such an advance care planning mechanism ensure respect for residents' treatment preferences at the end of life (Hickman *et al*, 2011), but, even have a mature POLST program, there was significant variation in POLST completion rates among nursing homes (Jennings *et al*, 2016). Intense antimicrobial use in long-term care facilities promotes the emergence and antimicrobial resistant and led to adverse effects as *C. difficile* (Nicolle, 2014). Yamada and Arai (2020) reported that long-term care burden more increased as the most aged country, but negative effect to high positive aging effect to achieve healthy longevity, pivotal to increase quality of a communi-

ty-based integrated healthcare system and accumulate further evidence on disability prevention.

Caring of aged population requires sufficient level of knowledge and skills as to gerontology, as knowledge about normal ageing process and expected changings as (physiological, psychosocial, functional, and cognitive changes), common health needs, chronic problems and its care, as well as applying concept of health promotion for older adults to provide individualized care plan, prevent functional decline and help to maintain health as long as possible (Thornlow, 2016).

Mohammed and Abdelaziz (2019) found that knowledge level of nurses care of elderly people was more than (70%) gave incorrect answers, and (72.8%) had unsatisfactory knowledge level of elderly people caring (9.20+/-7.83) score. Alharbi (2020) reported that more clinical courses on the geriatric care in undergraduate curriculum are a must with still room for improvements in training and preparedness of nurses entering geriatric care. He added that the Saudi Nursing Curriculum is demonstrably in allowing the outside training lectures and ward setting as well as in preparedness them to enter practice. Badin *et al.* (2023) reported on equine-assisted intervention (EAI) for older adults began to be published, no scientific study has examined the various elements that can limit or facilitate the implementation of EAI with older adults suffering from Alzheimer's disease (AD) in nursing homes showed that for 45% of participants, the main brake to implementing EAI is related to the institutional burden. The caregivers were those who put forward the most levers for the implementation of EAI with AD patients living in nursing homes

Conclusion and Recommendations

For patients in nursing homes, structured interviews done at the initial intake and then at periodic intervals are necessary to ensure that symptoms are being addressed and care goals are being met. The interviews provide an opportunity to discuss hospice options for

patients who are experiencing significant decline and/or are approaching death. Untreated pain is a particular concern for patients in palliative care, and it appears to be a particular issue for nursing home residents, especially those with cancer. Estimates were that up to 37% of nursing home residents and over 65% with cancer report pain. In one study, staff reported that more than 90% of nursing home and 70% of assisting residents had problems with cleanliness, including issues related to skin, oral care and required to manage incontinence. Medications they take on a daily or routine basis may adversely affect their appetite and contribute to nausea and constipation. Communication among nursing home residents, family caregivers, clinicians, and nursing home staff must meet residents' palliative care needs

Patients in nursing homes must be included in any and all decision making due to their decisional capacity. But, those without decisional capacity or with advanced dementia, these decisions fall on surrogate decision makers. Among frequent decisions faced by surrogate decision makers for residents with dementia involve establishment of goals of care, feeding, and medical complications treatment of infections and pain.

For long-term care residents, it is useful to prioritize the most important goals as those that prolong life, promote function, or maximize comfort.

Structuring discussion about primary goal of care may not only improve communication, but also aide in subsequent the decision making for long-term care ones.

There is a need to develop the nursing curriculum and promote innovative schemes that will increase the students' willingness to work with elderly, in geriatric departments or nursing hostels

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