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THE CHALLENGES FACED BY GERIATRIC NURSES LONG-TERMCAREFACILITIES

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Abstract

A comprehensive assessment of qualitative evidence on nurses' self-descriptions of their end-of-life care practice has not been conducted. The objective is to compile qualitative informationabouttheend-of-lifecarepracticesofnursesinlong-termcaresettingsforolderpersons.Published and unpublished research in English were searched for in the databases MEDLINE,CINAHL,PsycINFO,EMBASE,Mednar,GoogleScholar,andIchushi.Their137findings werecategorizedinto10distinctconclusions:assumingdiverseroupsandsubsequentlycombinedintothreesynthesizedrolestofacilitatethedignifiedpassingofresidents,requiring resourcesandsupporttomaintainprofessionaldedication,andexperiencingadiscrepancybetween responsibilities and authority, which impacts multidisciplinary collaboration. Nursesfulfill multifaceted duties as the healthcare providers with the greatest expertise in addressing theintricate demands of residents. Managers and politicians should provide nurses the authority toaddress the discrepancy and assist them in acquiring the necessary resources for end-of-life care,therebyensuringthatresidentspassawaywithdignity.

Keywords:end-of-life(EOL)interventions. care, elderly patients, review, geriatric nurses, nursing

Introduction

The provision of end-of-life (EOL) care for older persons in long-term care (LTC) settings isa matter of worldwide significance. End-of-life care refers to the support provided to individualsin the final stages of their life. According to the National Health Service UK (2018), this careencompassesphysical,spiritual,andpsychosocialassessment,treatment,andsupport.Itis administeredbyhealthcareprofessionalsandancillarystafftoindividualswithincurable

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conditions, as outlined by the Australian Commission on Safety and Quality Health Care (2015).The guideline also highlighted the need of providing assistance to families and caregivers, inkeepingwiththepalliativecareprinciplesoutlinedinworldwiderecommendations(WorldHealth Organization, 2018). With the increasing global population aging, there will be a greaterneed for end-of-life care in long-term care settings, as stated by the World Health OrganizationRegionalOfficeforEuropein2011.

Nevertheless, long-term care (LTC) facilities often fail to offer adequate end-of-life (EOL)care, as indicated by research conducted by Pivodic et al. in 2018. Many residents approachingtheendoftheirlivessufferfromuntreatedpain,ashighlightedbystudiesconductedbyAchterberg et al. in 2010 and Rajkumar et al. in 2017. Furthermore, these individuals experienceother avoidable symptoms due to subpar care, as well as negative psychosocial effects such asloneliness and depression. Unfortunately, support for theirspiritual needs is also limited, asnotedbyGreenwoodetal.in2018.Therehavebeenreportsoffamilymembersbeingdissatisfied with end-of-life treatment in long-term care (LTC) settings. This unhappiness hasbeenlinkedtoinadequatecommunicationbetweennurses,residents,andfamilymembers(Thompson,McClement,Menec,&Chochinov,2012).

Notwithstandingthesechallenges,long-termcare(LTC)facilitiesstilladmitelderlyindividuals with demanding and intricate health conditions that nurses may not be adequatelyequippedorqualifiedtohandle.Residentsfrequently experiencearangeofchronichealthconditions, including serious illnesses like cancer, stroke, or cardiac failure, as well as cognitiveimpairments or dementia, and behavioral and psychological issues that can hinder necessary care(Midtbust, Alnes, Gjengedal, & Lykkeslet, 2018; Vandervoort et al., 2013). The transition fromgeneral aged care to end-of-life (EOL) care is a problem due to the unpredictable timing ofresidents' approaching death.Frail older persons may passaway without a distinct terminalphase, andtheir dyingpatternsmightdiffer significantly (Lunney,Lynn,Foley,Lipson,&Guralnik,2003).Thepresenceofambiguityhasthepotentialtogenerate conflictamongresidents, families, and caretakers.Long-term care (LTC) nurses are responsible for managingtheintricaterequirementsofresidents,sincetheypossessthehighestlevelofexpertiseinunderstandingtheirphysicalandpsychologicalcondition,aswellastheirpreferencesanddesires.

Several systematic reviews have been conducted on end-of-life care in long-term care (LTC)settings for older persons, with a particular focus on advanced care planning (ACP). Thesereviews include studies by Beck, McIlfatrick, Hasson, and Leavey (2015), Gilissen et al. (2017),andMignani,Ingravallo,Mariani,andChattat(2017).Gilissenetal.(2017)conductedastudyof

37articlesandidentified17preconditionsthatarenecessaryforeffectiveAdvanceCarePlanning (ACP) in nursing homes. According to them, healthcare staff and the design of nursinghomes are crucial factors in the effectiveness of ACP. Additional systematic studies examinedcomplete geriatric evaluations (Hermans et al., 2014) or the experiences of elderly individualsnearingtheendoflifeinnursinghomes(Greenwoodetal.,2018).Nevertheless,thesestudies

failedtoprioritizenurses,whoarethemostcrucialhealthcareworkersinend-of-life(EOL)practice.

There are reviews available that examine the practice and duties of nurses in end-of-life care.However, there is a lack of reviews specifically focused on long-term care settings for olderpersons.Several research have examined the involvement of nurses in providing palliative carein homecare settings. These studies have shown that nurses play several roles in palliative careandplaceimportanceontheircontribution.However,theyalsofacechallengesrelatedtoemotional distress and ambiguity about their position. Karbasi, Pacheco, Bull, Evanson, andChaboyer (2018) conducted a comprehensive analysis of registered nurses' end-of-life care forpatientsadmittedtohospitals,usingacombinationofdifferentresearchmethods.

Nurses shown introspection in their professional conduct, although encountered situationalobstacles such as limited physical area, insufficient time, and inadequate training to provideexceptional end-of-life care. Sekse, Hunskar, and Ellingsen (2018) conducted a qualitative meta-synthesis to examine the role of nurses in palliative care across various health systems. Theirfindings revealed that nurses highly valued the responsibilities of "being available" to provideand coordinate care. To fulfill these roles effectively, nurses need enough information, training,direction, and support. The role of nurses in end-of-life care in long-term care (LTC) settingsshould be distinct from their position in hospital and homecare settings. This distinction isnecessary due to several contextual variations, such as the duration of residents' stay, the reasonof admission, the placement of physicians, and the nurse-resident/nurse-patient ratio. Moreover,nursing care in long-term care (LTC) settings is now lacking in development, since nurses havehistorically received training for employment in acutecare settings (Spilsbury, Hanratty, &McCaughan,2015).

2. End-of-life(EOL)care

End-of-life (EOL) care is a crucial skill that nurses in long-term care (LTC) settings mustpossess (Stanyon, Goldberg, Astle, Griffiths, & Gordon, 2017). These settings typically havemultidisciplinaryteamsconsistingofnurses,assistants,physicians,socialworkers,andvolunteers. It is important for all team members to have a clear understanding of their roles andfeelcomfortable in order tofacilitate effective collaboration. However, the end-of-life carepractices of nurses in long-term care settings for older persons have not been evaluated. Thesynthesisofqualitativeresearchonnurses'end-of-lifecarepractice shouldprovideaclearunderstanding of the necessary care to address the requirements of both residents and theirfamily.

3. Coordinatingcareinprognosticuncertainty

Nurses monitor patients closely to promptly identify physical indicators of impending death(Kobayashi & Yamashita, 2016). Falls, stroke, or infections are recognized as factors that canleadtoresidents'declineandoveralldecreaseinfunction.Thiscanmanifestaschangesin

behavior, loss ofappetite, anddiscussions about preparing for death,which are consideredindicators of impending mortality. When nurses recognize that residents are prepared to go, theyprovide clear end-of-life care (Porock & Oliver, 2007), assess the need for consultation with aphysician, and develop an end-of-life care plan (Kobayashi & Yamashita, 2016; Sakashita &Nishida,2012).

4. Facilitatingtheresolutionofdesiresintheprocessofmakingdecisionsforend-of-life care

In order to ascertain the desires of residents on end-of-life (EOL) matters, nurses activelyengage in conversations with residents about death (Wadensten et al., 2007) and facilitate thedisclosureoftheirideas(Kobayashi&Yamashita,2016).They may shieldresidentsfromcontemplating mortality by diverting their attention towards a different topic (Livingston et al.,2012; Wadensten et al., 2007). Resident's attitude towards death might be inferred by observingtheir behaviors, such as abrupt cessation of food or medication intake (Dwyer etal., 2010;Porock & Oliver, 2007). It is crucial to include residents, family, and clinicians (Gorlén et al.,2013;Kobayashi&Yamashita,2016)inAdvanceCarePlanning(ACP)toguaranteethepreservation ofresidents'preferences(Phillipsetal.,2006).

Inordertofacilitatecommunicationandaidinend-of-lifedecision-making,nursesuseindirectcommunicationtechniques(Lopez,2009).Nursesmayencounterchallengeswhenattempting to cease life-prolonging treatment or halt the transfer of residents to a hospital due tothe desires of family members (Ersek et al., 2000; Gorlén et al., 2013; Kobayashi & Yamashita,2016; Lopez, 2009) or the decision of a physician (Hov et al., 2013) when they are unable toverifythewishesoftheresidentsduringtheirfinaldays.

5. Enablingapainlessandpeaceful dying

Nurses strive to provide the highest comfort of residents (Kobayashi & Yamashita, 2016)."Asrequired"prescriptions,propermedicationadministration(Gorlénetal.,2013),andareliable evaluation instrument (Phillips et al., 2008) assist nurses in evaluating and relieving thesuffering and discomfort of residents. The challenges associated with this role (Dwyer et al.,2010; Irvin, 2000) include the limited proficiency among doctors, concerns among families overresidents' potential addiction to pain relief medication (Ersek et al., 2000), and the potential fortherapy to be administered against residents' preferences in order to fulfill the requests of theirfamily (Hov et al., 2013). The presence of dementia introduces additional complexities in thetreatmentofpainandsymptoms,sinceindividualsresidingincarefacilitiesmayexhibitresistancetowardsdrugadministration(Kaasalainenetal.,2007).

6. Supportingrelatives'coping

The study conducted by Sakashita and Nishida (2012) highlights the crucial role of nursingpractice in understanding and addressing the manner in which residents spend their last days andultimatelypassaway.Nursesareawareoftheuniqueidentitiesofresidents,includingtheir

culturalbackgrounds,personalbeliefs,andreligiousrequirements(Bottrelletal.,2001;Livingston et al., 2012; Dwyer et al., 2010; Hov et al., 2013). Society may neglect or disregardthem (Gannon & Dowling, 2011). Nurses establish emotional connections with residents (Erseket al., 2000) and cultivate robust (Irvin, 2000; Livingston et al., 2012), familial (Gannon &Dowling, 2011; Lopez, 2007; Phillips et al., 2006) bonds. Their objective is to provide end-of-life care with empathy (Hirakawa &Uemura,2013), concentrate on(Sakashita& Nishida,2012), and discover significance in (Dwyer et al., 2010) the daily lives of each resident till theveryend.Nursesfacilitatethetransportationofresidentstositesthatareknowntothem(Kobayashi & Yamashita, 2016) and enable them to bid farewell to their families and the staff(Porock & Oliver, 2007). Nurses advocate for the belief that no one should experience death insolitude, as supported by research conducted by Gannon & Dowling (2011), Kaasalainen et al.(2007),andPorock&Oliver(2007).

7. Assistingfamilymembersinmanaging theiremotionalresponse

It is important to communicate a resident's status to their families, including informationaboutanticipatedchangesinsymptomsandthetransitiontoend-of-lifecare.Engagingincooperationwithfamilymembersisalsocrucialforachievingeffectiveend-of-lifecare(Hirakawa & Uemura, 2013). Due to the less than ideal conditions in long-term care (LTC)facilitiesforfamilytospendtimewiththeirdyinglovedones,nursesmodifythepatients'areastoaccommodatetherelativesandenablethemtofreelyvisit(Gannon&Dowling,2011;Kobayashi & Yamashita, 2016). Assisting family members in managing emotions of guilt anddespair (Kaasalainen et al., 2007) is an essential aspect of a nurse's responsibility in end-of-lifecare. Nurses facilitate communication with family to assist them in articulating their emotionstowardstheresidents(Kobayashi&Yamashita,2016).Developingstrongtieswithfamilymemberspromoteseffectivecopingmechanismsforrelatives(Gorlénetal.,2013),hencedecreasingthe likelihoodoflitigationandassigning blame(Livingstonet al.,2012; Lopez,2009).

Ensuringapainlessanddignifieddeathforresidents,despitetheproblemsposedbydementia-related medication refusal, remains a complex task. This issue has been addressed inearlier research by Barry, Parsons, Passmore, and Hughes (2015) and Rajkumar et al. (2017).Recently,researchershavecreatednewtechniquestomeasurepaininolderpersonswithdementia in long-term care (LTC) settings (Chow et al., 2016). Long-term care (LTC) nursesneed training assistance to acquire proficiency in providing palliative care for individuals withdementia.Additionally,furtherresearchisnecessarytodevelopwaysthatpromoteapainlessandpleasantdyingforindividualswithdementia.

Nurses in long-term care (LTC) settings have been shown to play a crucial role in advocatingfor residents (Dahlin, 2010), especially considering that the cognitive capacity of most patientstends to deteriorate. This advocacy role aligns with end-of-life care in several contexts (Karbasietal.,2018;Sekseetal.,2018).Nevertheless,nursesalsoreportedthatthedignityofdying

residents was compromised by unneeded medical interventions aimed at prolonging their lives,which went against the residents' own preferences but aligned with the desires of their family. Itwasproposedthatprovidingsupporttofamilyindealingwiththedeathofresidentsiscrucial,notonlyfor thepleasureoftherelativesbutalsoforupholdingthedignityofthedyingresidents.

Long-term care nurses should confront the task of reconciling the desires of residents andtheir family members. Nurses' capacity to determine residents' attitudes was influenced by theirconfidence and understanding of ACP (Froggatt, Vaughan, Bernard, & Wild, 2009). Engaging intraining to enhance these abilities would enable nurses to effectively negotiate and advocate forresidents'preferences whilemakingdecisionsonend-of-lifecare.

Establishing connectionswithpatients iscrucialforenabling personalizedhealthcareinhospital or homecare settings (Sekse et al., 2018; Walshe & Luker, 2010). In long-term care(LTC) settings, the enduring connections formed between nurses and residents enable nurses toprovide compassionate care by consistently being there for the residents. Nevertheless, nursesmayhavetrepidationandadesiretoavoidconfrontingthedeathofresidentsduetotheemotionalbondakintothatofafamily.

Nursesneedassistanceandaccesstoresourcesinordertomanagetheemotionalconsequencesofprovidingcareforterminallyillindividuals.Allocatingsupplementarypersonnel might assist them in finding time to confront the mortality of residents, despite theirdemanding task. Emotional support may assist individuals in managing their own loss and stress.Furthermore, providing educational assistance on communication skills and the significance ofreligion might assist individuals in understanding their responsibility of offering care to dyingpeople.

Thisanalysisisalsorevealedthatnursesassumethepositionofcoordinatoramongthemultidisciplinaryteamsoftenseeninlong-termcare(LTC)settings.Thepaperfurtherhighlighted the importance of cooperation among healthcare professionals, which aligns withearlier research conducted by Leclerc et al. (2014) in LTC settings. Nevertheless, long-term care(LTC) nurses sometimes have challenges in effectively communicating with and experiencing alackof appreciationfromother healthcarepractitioners,particularly doctors,comparabletonursesinotherhealthcareenvironments(Sekseetal.,2018;Walshe& Luker,2010).

Several studies have shown that doctors in certain situations have recognized and appreciatedthe expertise and abilities of nurses. For example, Hanson, Henderson, and Menon (2002) foundthat physicians acknowledged their dependence on nurses' capabilities. Additionally, Dreyer,Førde, and Nortvedt (2011) found that physicians respected nurses' competences in geriatrics orpalliative care. Long-term care (LTC) nurses should be held responsible for their own role inproviding high-quality end-of-life (EOL) care. They should also be given the authority, alongwith appropriate education and training, to make decisions regarding EOL issues like hydrationor tube-feeding. This includes the ability to negotiate and collaborate with other healthcareprofessionalsbasedontheirownexpertise.Nurseswhoaregivenauthorityandsupportwill

acquirethenecessaryresourcestofulfilltheirextensiverangeofresponsibilities,inordertoassistresidentsinexperiencingadignifieddeath.

8.Conclusion

This systematicreviewconducted a meta-aggregation of primary qualitative research tosynthesis the end-of-life care practice of nurses in long-term care settings for older persons. LTCnurses assume multifaceted responsibilities in order to assist residents in achieving a dignifieddeath. In order to maintain their professional devotion to their jobs, they need resources andassistance. They prioritize collaborating with other healthcare professionals on end-of-life care,but they see a discrepancy between their obligations and their authority, which has a detrimentalimpactoncooperation,particularlywithdoctors. Long-term care (LTC)nursesneed assistanceinaddressingthetaskoffacilitatingthedignifieddeathofpatients.Thisincludesmitigatingresidents'painandreconcilingthedesiresofresidentswithcognitivedeclineordementia.Managers andlegislatorsshouldprovideLTCnursestheauthority andsupportthey need tofulfill their duties and ensure that their expertise and advocacy are recognized and valued incollaborative care. Additional study is required to elucidate the impact of cultural and systemicfactors in long-term care (LTC) settings on end-of-life (EOL) nursing practices across differentnations.

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