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Preparing the Nursing Workforce for the Care of Older Adults with Complex Neurocognitive Disorders in Under-Resourced Long-Term Care Environments: A Narrative Review

Fulla Ali Makwa[1], Abdullah Yousef Habbash[2], Amal Ali Hassan Swade[3], Faris Abdulaziz Alrudayni[4], Fatimah Mohammed Ali Faqih[5], Majed Ali Dhaifullah Faqiri[6], Nourah Saeed Ali Alsahohi[7], Abeer Awaidah Alrwaili[8], Nada Owaidhah Alrawaili[9], Fatimah Qasem Shamhan[10], Ahmad Mousa Yahia Khawaji[11], Hana Eidhah Almuwallad[12], Maha Mohammed Basheri[13]

[1]Al Ardah General Hospital, Jazan, Ministry of Health, Saudi Arabia.
Email: Fmekawai@Moh.Gov.Sa
[2]Sabya General Hospital, Sabya, Ministry of Health, Saudi Arabia.
Email: vip125.abdullah@gmail.com
[3]Primary Healthcare Center, Samtah, Jazan Health Cluster, Ministry of Health, Saudi Arabia. Email: aswade@moh.gov.sa
[4]General Directorate of Emergencies, Disasters and Medical Transport, Riyadh, Ministry of Health, Saudi Arabia. Email: Falrudayni@moh.gov.sa
[5]Abu Arish General Hospital, Jazan, Ministry of Health, Saudi Arabia.
Email: ffaqih@moh.gov.sa
[6]Prince Mohammed Bin Nasser Hospital, Jazan Health Cluster, Ministry of Health, Saudi Arabia. Email: mjdfqyry@gmail.com
[7]Al Baha Health Cluster, Ministry of Health, Saudi Arabia. Email: nalsahohi@moh.gov.sa
[8]King Abdulaziz Specialist Hospital, Al Jouf, Ministry of Health, Saudi Arabia.
Email: Abaalrwaili@moh.gov.sa
[9]Dumat Al Jandal General Hospital, Al Jouf, Ministry of Health, Saudi Arabia.
Email: 177nada@gmail.com
[10]Al Humma Primary Healthcare Center, Damad, Jazan, Ministry of Health, Saudi Arabia.
Email: fatmahshamhan@hotmail.com
[11]Sabya General Hospital, Ministry of Health, Saudi Arabia.
Email: amkhawaji@moh.gov.sa
[12]Ibn Sina Extended Care Hospital, Makkah, Ministry of Health, Saudi Arabia.
Email: haaalmowald@moh.gov.sa
[13]Sabya General Hospital, Jazan, Ministry of Health, Saudi Arabia.
Email: bbmaha599@gmail.com

ABSTRACT: Nurses are central to person-centred dementia care, yet older adults with complex neurocognitive disorders (NCDs) increasingly live in long-term care (LTC) settings where staffing is thin, training is limited, and resources are scarce. This narrative review synthesises literature published between 2017 and 2024 on how the nursing workforce can be prepared to deliver safe, person-centred care in such environments. Evidence indicates that complexity arises from the interaction of behavioural symptoms,

delirium, pain, multimorbidity, and end-of-life needs with organisational constraints. Effective preparation combines core competencies, practice-based and supervised learning, structured non-pharmacological approaches, and organisational enablers such as leadership, family partnership, and supportive environments. A conceptual framework, a tiered response model, and a staged competency pathway for nurses are proposed. Findings suggest that low-cost, workplace-embedded education reliably improves practice only when coupled with workforce valuation, adequate staffing, and sustained system investment. Priorities for policy, practice, education, and research are identified and discussed.

INTRODUCTION

Population ageing is transforming the demand for long-term care worldwide. Dementia, the most common cause of complex neurocognitive disorders (NCDs) in later life, affects an estimated 57 million people, and projections suggest that this figure could reach almost 153 million by 2050, with the steepest growth expected in low- and middle-income countries (LMICs) (Nichols et al., 2022). The World Health Organization (2021) reports that national responses, including planning for the dementia care workforce, remain uneven across regions. Although relatives support most people with dementia at home for much of the illness, advancing cognitive and functional decline, behavioural symptoms, and carer exhaustion mean that many eventually require care in nursing homes, residential facilities, or other long-term care (LTC) settings (Babulal et al., 2024; Gauthier et al., 2022).

In this review, complex NCDs refers to major neurocognitive disorders, including Alzheimer's disease, vascular dementia, dementia with Lewy bodies, frontotemporal dementia, and mixed presentations, in which cognitive impairment co-occurs with behavioural and psychological symptoms, delirium, pain, multimorbidity, sensory loss, or advancing frailty. This complexity is the norm rather than the exception in LTC. Residents typically have moderate to severe impairment, limited ability to express needs verbally, and a high burden of coexisting illness, so that every care decision requires nurses to interpret ambiguous signals, weigh competing risks, and preserve personhood (Fazio et al., 2018). The 2020 Lancet Commission described dementia care as requiring individualised, multicomponent, and coordinated approaches across the course of the illness, an aspiration that presupposes a workforce with the knowledge, time, and authority to deliver it (Livingston et al., 2020).

Nurses, together with the care assistants whom they supervise and support, deliver most day-to-day dementia care in LTC, yet the nursing workforce is itself under strain. The World Health Organization (2022) estimated that the world had about 27.9 million nurses and faced a shortfall of roughly 5.9 million, concentrated in lower-income regions. LTC is often the least attractive and least resourced segment of the health system for nurses, characterised by low pay, limited career pathways, and weak access to continuing education (McGilton et al., 2020; Scales, 2021). Where facilities operate with minimal staffing, few registered nurses, little specialist input, and almost no funding for education, as in many LMICs and in under-funded facilities in high-income countries, the preparation of nurses for complex NCD care cannot be assumed to follow conventional models (Estabrooks et al., 2020; Ferri & Jacob, 2017). In this review, under-resourced describes LTC environments in which staffing, funding, specialist access, or educational infrastructure are persistently insufficient for the needs of residents.

The stakes are high. Poorly prepared care environments are associated with avoidable distress for residents, reliance on sedating medication and physical restraint, family dissatisfaction, and moral distress among staff, whereas well-prepared teams can improve comfort, preserve function, and support dignity at the end of life (Ballard et al., 2018; Livingston et al., 2020). Evidence on dementia education is growing, but much of it describes programmes delivered in well-staffed facilities in high-income settings, with trained facilitators and protected learning time (Surr et al., 2017). Nurses in under-resourced environments face different constraints, and guidance that ignores them risks being irrelevant at best and demoralising at worst.

Despite a substantial literature on dementia education and non-pharmacological care, few syntheses address how nurses can be prepared when resources are scarce. This narrative review therefore aims to (a) characterise the care complexity facing nurses; (b) describe the structural constraints of under-resourced LTC; (c) propose a conceptual framework and identify core competencies; (d) appraise educational and organisational strategies; and (e) outline implications for practice, policy, and research.

REVIEW APPROACH

This paper is a narrative review, an approach suited to integrating heterogeneous evidence, including trials, systematic reviews, qualitative studies, and policy reports, on a broad and applied question for which a formal systematic synthesis is neither feasible nor appropriate. The review was structured around quality principles for narrative reviews: a justified aim, a transparent search approach, comprehensive referencing, sound scientific reasoning, and appropriate presentation of evidence.

Literature published between 2017 and 2024 was identified through purposive searching of major bibliographic databases (MEDLINE/PubMed, CINAHL, and Scopus) and the publications of international organisations, using combinations of terms related to dementia or neurocognitive disorder, nursing education and workforce, long-term care or nursing homes, and low-resource settings. Reference lists of key reviews were examined for additional sources. Priority was given to systematic reviews, randomised trials, large cohort studies, and authoritative guidance, while qualitative studies and commentaries were used to illuminate context and implementation.

The review adopted a pragmatic, problem-oriented lens. Rather than cataloguing every dementia intervention, it asked what a nurse needs to be able to do, what enables or prevents learning from becoming practice, and what is realistically achievable when time, money, and specialist support are limited. Studies were therefore valued for what they revealed about mechanisms and implementation as well as for effect sizes. Literature on acute hospital dementia care was used only where it offered transferable insights for LTC.

Evidence was synthesised thematically rather than statistically. Because most trials were conducted in high-income countries, transferability to under-resourced settings was considered explicitly, and the recommendations offered for such settings are presented as reasoned extrapolations rather than proven interventions. The conceptual framework and models in Figures 1 to 3 are the author's synthesis of the reviewed literature and have not been empirically validated.

CLINICAL COMPLEXITY OF CARE FOR OLDER ADULTS WITH COMPLEX NCDS

Epidemiology and Trajectory

Dementia is a leading cause of disability and dependence in later life, and its burden is shifting toward LMICs. Nichols et al. (2022) projected that the number of people with dementia would almost triple by 2050, with the largest relative increases in North Africa and the Middle East and in sub-Saharan Africa. Population-attributable analyses suggest that a substantial proportion of dementia in LMICs is linked to modifiable factors such as low educational attainment, hypertension, and hearing loss (Mukadam et al., 2019), so that prevention needs and care needs coexist within the same communities. Livingston et al. (2017) and Livingston et al. (2020) identified, respectively, nine and twelve modifiable risk factors, the latter accounting for about 40% of dementia worldwide. For LTC nurses, the practical implication is that residents arrive late in the illness trajectory, often with limited prior diagnostic work-up, and with needs that evolve rapidly.

Reports on the dementia care landscape consistently note that formal diagnosis is delayed or absent for many people, particularly in lower-income settings, and that the burden on family caregivers is substantial (Babulal et al., 2024; Gauthier et al., 2022). Nurses admitting a new resident should therefore not assume that a reliable diagnosis, a documented history, or a complete medication record is available, and must be prepared to build a picture of the person through observation and conversation with relatives.

Behavioural and Psychological Symptoms

Behavioural and psychological symptoms of dementia, including agitation, aggression, apathy, psychosis, sleep disturbance and repetitive vocalisation, affect most people with dementia at some point and are among the main reasons for institutional admission and psychotropic prescribing. An international Delphi consensus emphasised that these symptoms often communicate unmet need, that physical and environmental causes should be sought first, and that non-pharmacological strategies should be the first-line response, with antipsychotic medication reserved for severe symptoms that cause marked distress or danger (Kales et al., 2019). Reviews of non-pharmacological practices have identified person-centred, individualised, and activity-based approaches as the most consistently supported, although the quality and consistency of the evidence vary considerably (Dyer et al., 2018; Scales et al., 2018).

Delirium, Pain, and Multimorbidity

Delirium superimposed on dementia is common, frequently unrecognised, and associated with accelerated cognitive decline, functional loss, and mortality; hypoactive presentations are easily mistaken for progression of dementia or for withdrawal (Oh et al., 2017). Because pain and infection present atypically in people unable to self-report, nurses must rely on observation, behavioural cues, and knowledge of the individual. Polypharmacy compounds the problem. Maust et al. (2021) showed that central nervous system-active polypharmacy was common among older adults with dementia in the United States, with attendant risks of falls, sedation, and further cognitive impairment. In under-resourced facilities, where physician review may be infrequent, the nurse is often the only clinician placed to notice that a change in behaviour reflects an acute medical problem or a medication effect.

Advanced Illness and End of Life

Advanced dementia is a terminal condition, and the final year of life is marked by substantial symptom burden. In a prospective cohort of people with advanced dementia in the United Kingdom, Sampson et al. (2018) documented frequent pain, agitation, and other distressing symptoms alongside considerable unmet needs for care and support. Families are central to decision-making at this stage, and the COVID-19 pandemic highlighted how visiting restrictions disrupted both end-of-life care and family bereavement (Moore et al., 2020). Nurses therefore require palliative competencies, including comfort-focused care planning, communication about prognosis, and ethically sound decision-making, in addition to the competencies of everyday dementia care.

Why Complexity Is Amplified in Long-Term Care

Several features of LTC amplify clinical complexity. Residents' communication is limited by cognitive and sensory impairment, so that symptoms must be inferred. Care is delivered in group living environments in which the behaviour of one resident affects others and routines are shaped by staffing rather than by individual preference. Continuity of clinical oversight is often weak, with medical review infrequent and diagnostic services distant. Residents also experience transitions, such as hospital admission, that can precipitate delirium and loss of function. Nurses must therefore integrate clinical reasoning, relational skill, and organisational navigation in ways that few educational programmes explicitly address. Where staffing is thin, the time available for individualised assessment and relational care shrinks precisely when needs are greatest, creating a cycle in which unmet need leads to distress, distress leads to behaviours that are labelled challenging, and these behaviours attract medication or restraint (Kales et al., 2019; Maust et al., 2021).

THE UNDER-RESOURCED LONG-TERM CARE CONTEXT

Staffing and Work Environment

Staffing is the most consistently identified constraint. Harrington et al. (2020) proposed minimum standards of 4.1 total nursing hours per resident per day for United States nursing homes, including 0.75 registered nurse hours, and noted that a large proportion of facilities fall short. Evidence from nursing homes indicates that poor work environments are associated with registered nurse burnout, job dissatisfaction, and missed care (White et al., 2019; White et al., 2020). A systematic review and meta-analysis of staff in LTC facilities for people with dementia found substantial levels of stress and burnout, which are likely to be amplified when ratios are low and behavioural symptoms are frequent (Costello et al., 2019). Understaffing therefore directly erodes the capacity to apply the person-centred and non-pharmacological approaches that nurses may have been trained to use.

Workforce Status, Skill Mix, and Education

In many LTC settings, unlicensed care assistants provide most direct care, while registered nurses are few and often occupied with administrative, medication, and regulatory tasks. Scales (2021) argued that direct care work is undervalued and poorly supported, with low wages, limited training, and few opportunities for progression, and called for the transformation of these jobs as a precondition for quality care. McGilton et al. (2020) similarly described the devaluation of nursing home staff, which became starkly visible during the COVID-19 pandemic. Under such conditions, nurses carry the dual burden of clinical responsibility and the supervision of poorly prepared colleagues, yet rarely receive formal preparation for either role.

Moral Distress, Turnover, and the Erosion of Expertise

Nurses who understand what good dementia care involves but cannot deliver it because of staffing constraints are at risk of moral distress, a form of suffering that is commonly associated with burnout and intention to leave. The consequence for workforce preparation is that investment in individual nurses may be lost when they depart, taking tacit expertise with them. High turnover also undermines continuity of relationships with residents, which is central to person-centred care (Fazio et al., 2018). White et al. (2019) reported that burnout and dissatisfaction among nursing home registered nurses were linked to missed care, suggesting a pathway through which workforce strain translates into unmet resident needs. Strategies that support well-being, voice, and a sense of competence are therefore not optional extras but part of workforce preparation (Costello et al., 2019; McGilton et al., 2020).

Low- and Middle-Income Country Realities

In LMICs, formal LTC is often undeveloped, dementia is under-recognised, and family care is the predominant model (Ferri & Jacob, 2017). Those authors argued that dementia care in these settings requires tailored solutions that fit local health systems, cultural beliefs, and available human resources rather than direct transfer of high-income models. Stigma is a significant barrier. In a qualitative study in South Africa, Mkhonto and Hanssen (2018) described how people with dementia were sometimes perceived as witches, with serious consequences for their safety and challenges for nurses seeking to provide respectful care. The World Health Organization (2017) global action plan identifies the training of health and care workers as a component of diagnosis, treatment, care, and support, yet the 2021 status report documents that implementation lags behind these commitments, especially in lower-income countries (World Health Organization, 2021).

Crisis Conditions

The COVID-19 pandemic exposed the fragility of LTC systems. Estabrooks et al. (2020) concluded that chronic underfunding, staffing shortages, and fragmented oversight in Canadian LTC contributed to avoidable harm and recommended structural reforms to restore trust. The experience illustrates that educational interventions alone cannot compensate for deficits in staffing and system support, a point that recurs throughout this review.

A CONCEPTUAL FRAMEWORK FOR WORKFORCE PREPARATION

Synthesising the evidence above, Figure 1 presents a framework linking resident complexity, workforce preparation, and outcomes within a context of organisational enablers and resource constraints. The central proposition is that the complexity of residents' needs generates a set of nursing competencies, but that the translation of these competencies into better outcomes is conditional on organisational enablers, such as leadership, supervision, and adequate staffing, and is constrained by under-resourced conditions. The framework is anchored in person-centredness, which Dewing and McCormack (2017) have shown to be variously defined, and which is here operationalised through the practice recommendations of Fazio et al. (2018): knowing the person, recognising and accepting the person's reality, supporting meaningful engagement, nurturing authentic relationships, creating a supportive community, and evaluating care practices.

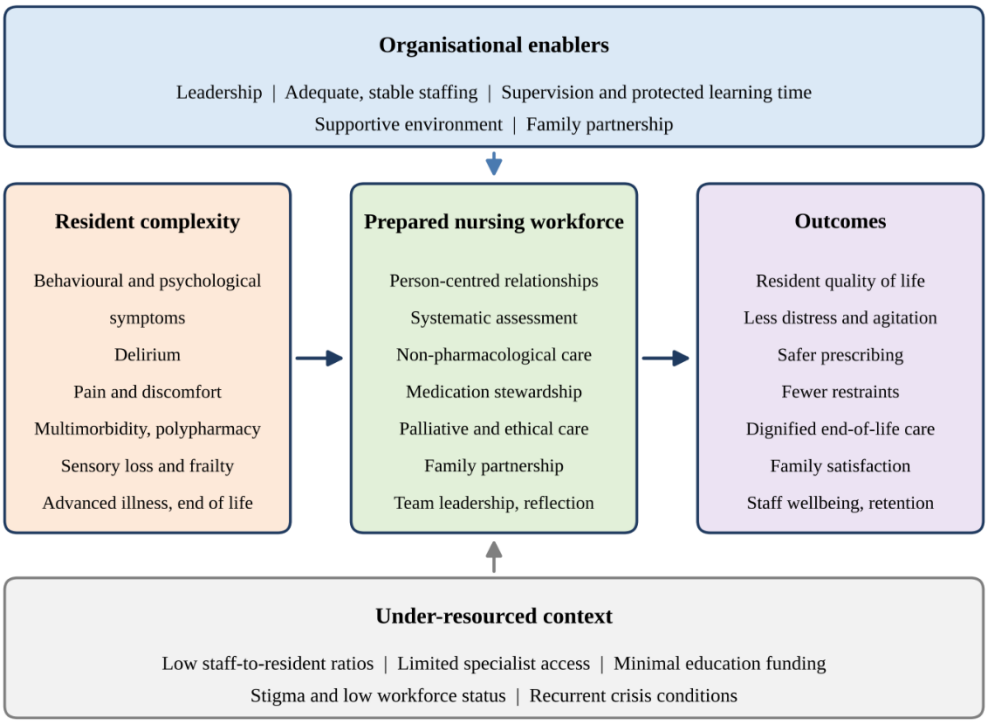


Figure 1. Conceptual Framework for Preparing the Nursing Workforce in Under-Resourced Long-Term Care

Two implications follow. First, preparation must be defined by the clinical problems nurses face rather than by generic dementia awareness. Second, because enabling conditions determine whether training translates into practice, workforce preparation is best conceived as an organisational and system intervention rather than a purely individual educational one. The remainder of this review is structured accordingly.

The framework also clarifies what should be measured. Resident-level outcomes include quality of life, distress, function, and comfort, whereas staff-level outcomes include knowledge, confidence, burnout, and retention. Organisational outcomes include prescribing patterns and restraint use. Because under-resourced facilities rarely have research capacity, the indicators proposed in Table 1 are deliberately simple. The framework further assumes that effects are reciprocal: improved outcomes, such as reduced agitation, may in turn ease workload and improve morale, creating a virtuous cycle that helps to sustain practice (Ballard et al., 2018; Chenoweth et al., 2019).

CORE COMPETENCIES FOR NURSES IN COMPLEX NCD CARE

Table 1 summarises six competency domains derived from the literature, together with learning outcomes, low-cost learning strategies suited to under-resourced settings, and practice indicators that can be monitored without sophisticated information systems. The domains are discussed in turn.

Table 1. Core Competency Domains, Learning Strategies, and Practice Indicators for Nursing Care of Older Adults with Complex NCDs in Under-Resourced LTC

Competency domain	Key learning outcomes	Low-cost learning strategies	Practice indicator
Person-centred relationship and communication	Elicit life stories; interpret verbal and non-verbal cues; offer choice; respond to distress with validation (Fazio et al., 2018; Kim & Park, 2017)	Life-story sheets completed with families; role-play during huddles; peer observation	Proportion of residents with a current life-story summary

Systematic assessment and recognition of deterioration	Recognise delirium; observe pain; screen for infection, constipation, and sensory loss; maintain function (Cations et al., 2018; Oh et al., 2017)	Case-based teaching with real residents; laminated checklists; bedside mentoring	Documented pain and delirium screening after a change in behaviour
Non-pharmacological and responsive care	Select individualised activity, music, and sensory approaches; adapt routines and environment (Abraha et al., 2017; Scales et al., 2018)	Staff-led coaching; shared activity boxes; community volunteers	Residents with an individual activity plan; documented distress episodes
Medication stewardship and restraint reduction	Identify adverse drug effects; question unnecessary psychotropics; use alternatives to restraint (Maust et al., 2021; Möhler et al., 2023)	Medication review huddles with a visiting prescriber; case discussion	Documented antipsychotic reviews; number of restraints in use
Palliative, ethical, and family-partnership care	Plan comfort-focused care; discuss prognosis; support families; reason ethically (Backhaus et al., 2020; Sampson et al., 2018)	Family-meeting role-play; reflective debriefing after deaths	Documented goals-of-care discussions; family involvement in care plans
Team leadership and reflective practice	Lead case conferences; coach care assistants; manage personal stress (Costello et al., 2019; Lichtwarck et al., 2018)	Weekly nurse-led case review; peer support groups	Case reviews held; staff turnover and sickness absence

Note. NCDs = neurocognitive disorders; LTC = long-term care.

Person-Centred Relationship and Communication

The foundation of dementia nursing is the ability to know the person and to communicate in ways that preserve dignity. A systematic review and meta-analysis of person-centred care found modest but consistent benefits for agitation and neuropsychiatric symptoms in people with dementia (Kim & Park, 2017). At the organisational level, a systematic review of person-centred care implementation concluded that the evidence is promising but limited by methodological weaknesses and that sustained change requires commitment from the whole organisation rather than from individual nurses (Chenoweth et al., 2019). For nurses, this domain includes eliciting life histories, interpreting verbal and non-verbal communication, offering choice, and responding to distress with validation rather than correction. These skills are largely cost-free to practise, which makes them an appropriate starting point in resource-scarce environments.

Systematic Assessment and Recognition of Deterioration

Nurses need structured ways to detect and interpret change. This includes recognising the cardinal features of delirium and its hypoactive forms (Oh et al., 2017), using observational pain tools, screening for infection, constipation, urinary retention, and sensory impairment, and documenting behaviours in terms of antecedents, behaviour, and consequences. The consensus approach of Kales et al. (2019) places such assessment of causes before any symptomatic treatment. A related competency is function-focused care. Cations et al. (2018) argued that people with dementia can benefit from rehabilitation and that low expectations are a barrier, which suggests that nurses should be prepared to maintain mobility, continence, and self-care rather than defaulting to dependency in under-staffed routines.

Non-Pharmacological and Responsive Care

Nurses should be able to select and deliver practical non-pharmacological interventions matched to the person. An overview of systematic reviews found that several approaches, including music-based, sensory, and activity-based interventions, show promise for behavioural and psychological symptoms, although the certainty of the evidence is variable (Dyer et al., 2018). A systematic review of systematic reviews identified music therapy, massage, and behaviour management techniques as having the most support for reducing behavioural disturbances (Abraha et al., 2017), while a Cochrane review concluded that music-

based interventions may improve emotional well-being and reduce depressive symptoms, though the evidence was of low to moderate quality (van der Steen et al., 2018). The WHELD cluster randomised trial showed that person-centred care training combined with social interaction and exercise-based activities improved quality of life and reduced agitation and antipsychotic use in nursing home residents (Ballard et al., 2018). Figure 2 sets out a tiered response model that organises these practices so that nurses with limited time apply the least intensive effective approach first.

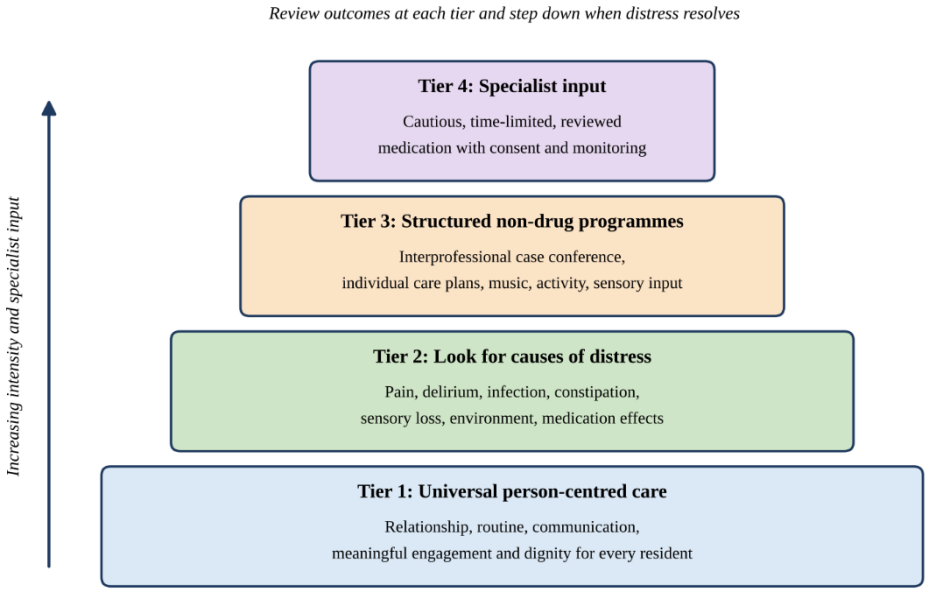


Figure 2. Tiered Response Model for Distress in Residents With Complex Neurocognitive Disorders

In practice, the tiers work as follows. Tier 1 is delivered to every resident through routines that respect individual preferences. Tier 2 is triggered when a resident shows new or escalating distress: the nurse looks first for pain, delirium, infection, constipation, hunger, thirst, sensory loss, and environmental triggers (Kales et al., 2019; Oh et al., 2017). Tier 3 is reserved for symptoms that persist despite correction of causes and involves a structured, team-based plan with specific activities or sensory approaches matched to the person's history (Abraha et al., 2017; Scales et al., 2018). Tier 4 involves specialist consultation and, where unavoidable, time-limited medication with defined targets and review dates (Kales et al., 2019). The model's principal value in under-resourced settings is that it makes the order of response explicit, so that an overstretched nurse does not skip directly to sedation.

Consider, as a hypothetical illustration, a resident with moderate Alzheimer's disease who begins shouting and resisting care each evening. A nurse prepared in this way would check for pain and constipation, review recent medication changes and sleep, notice that the resident has been moved to a noisier room, and speak with the family about the resident's evening routines as a retired farmer. A simple plan of an earlier supper, a quiet walk, familiar music, and a dedicated carer for the first hour of the evening might be tried and reviewed after a week. Such an approach demands knowledge and judgement more than equipment, and illustrates why competencies, rather than technology, are the central investment.

Medication Stewardship and Restraint Reduction

Because specialist prescribers are scarce in many LTC settings, nurses exert considerable influence over medication use through observation, documentation, and escalation. Competencies include recognising adverse effects of psychotropic drugs, challenging unnecessary prescribing, and advocating for review, in line with evidence that CNS-active polypharmacy is common and hazardous in dementia (Maust et al., 2021) and with the WHELD finding that reduced antipsychotic use is achievable alongside improved outcomes (Ballard et al., 2018). Restraint reduction is a related ethical priority. A Cochrane review of interventions to reduce physical restraints in long-term geriatric care found that the evidence is limited and of low certainty, which underlines that educational interventions alone are insufficient and must be accompanied by organisational policy and environmental change (Möhler et al., 2023).

Palliative, Ethical, and Family-Partnership Competencies

Given the symptom burden documented at the end of life (Sampson et al., 2018), nurses require skills in comfort-focused care, prognostic communication, and advance care planning. Family involvement is equally important. A systematic review of interventions to foster family inclusion in nursing homes for people with dementia found a limited evidence base but identified approaches such as staff training in communication and structured family participation in care planning as promising (Backhaus et al., 2020). In many LMIC settings, families remain primary caregivers even when the person is admitted, and nurses may need to work with relatives as partners rather than visitors (Ferri & Jacob, 2017). Pandemic experience further showed that nurses must be prepared to support families through separation and bereavement (Moore et al., 2020).

Where legal frameworks for advance care planning are absent or culturally unfamiliar, nurses may need to negotiate a shared understanding of goals of care with families through repeated, respectful conversations focused on comfort, avoidance of burdensome interventions, and the person's known values. Such conversations are easier when nurses have an established relationship with the family and are confident that their role includes this kind of communication.

Team Leadership and Reflective Practice

Finally, nurses must lead and coordinate care. Structured interprofessional models can make this feasible even with scarce specialist input. Lichtwarck et al. (2018) tested a targeted interdisciplinary model for evaluation and treatment of neuropsychiatric symptoms in nursing homes, in which staff were trained to conduct structured assessments, hold case conferences, and develop individual care plans, and reported improvements in resident outcomes. The elements of this model, namely structured assessment, case discussion, planned intervention, and evaluation, are transferable in form to low-resource settings through nurse-led huddles even in the absence of physicians. Reflective practice and peer support also protect against the stress and burnout documented among LTC staff (Costello et al., 2019).

EDUCATIONAL AND TRAINING STRATEGIES

What the Evidence on Dementia Education Shows

A systematic review of dementia education and training for the health and social care workforce concluded that effective programmes tend to be delivered face to face, use active and practice-based learning, are of sufficient duration, are supported by managers, and link content to real work situations (Surr et al., 2017). A companion synthesis for hospital staff highlighted similar elements and the importance of organisational support for translating learning into practice (Surr & Gates, 2017). A review of psychosocial interventions delivered by care home staff found that effective interventions were typically individualised and supported by ongoing training or supervision (Rapaport et al., 2017). The consistent message is that one-off didactic sessions seldom change practice. Preparation must be experiential, repeated, and embedded in the workplace.

Low-Cost, Workplace-Embedded Approaches

In under-resourced settings the challenge is to achieve these characteristics without large budgets or substantial release time. Five approaches appear feasible. First, short modules of 15 to 30 minutes can be integrated into handovers or shift huddles, avoiding the need for off-site courses. Second, mentoring and coaching by a more experienced nurse, even where that person is the only one with additional training, can convert classroom knowledge into bedside skill. Third, structured case reviews using real residents allow nurses to practise assessment and problem-solving collectively. Fourth, locally adapted tools, such as one-page behaviour charts and pain observation checklists, reduce reliance on documentation systems. Fifth, peer learning networks across facilities, supported by telephone or messaging groups, allow isolated nurses to obtain advice from colleagues and specialists. The WHELD trial demonstrates that a training and coaching model for care home staff can improve outcomes at scale (Ballard et al., 2018), and the model has been delivered through staff-led coaching rather than specialist-led therapy.

A train-the-trainer approach is a pragmatic strategy for spreading learning. A nurse or senior carer who completes a more intensive course can then facilitate short sessions for colleagues, consistent with the coaching model used in WHELD (Ballard et al., 2018). Risks include overloading the trainer, loss of fidelity as content passes through successive layers, and loss of the trainer through turnover. Mitigations include providing scripted session guides, pairing trainers with a mentor, formally recognising the role, and training more than one champion per facility. Evaluating fidelity and outcomes, even simply, helps ensure that cascaded training retains its quality (Rapaport et al., 2017).

Because care assistants deliver most hands-on care, nurse preparation should include supervising and teaching them. Training nurses and care assistants together builds a shared language and mutual respect, and recognises that the knowledge of experienced care assistants about individual residents is a resource rather than a deficit. This approach is consistent with calls to value direct care work as skilled (Scales, 2021) and with evidence that effective training is linked to real work situations (Surr et al., 2017).

Technology-Enabled and Simulation Approaches

Technology may extend capacity but is not a substitute for staffing. A scoping review of virtual reality simulation in dementia care education suggested benefits for empathy and knowledge but limited evidence on sustained changes in practice or patient outcomes, and noted cost and access barriers (Hirt & Beer, 2020). Social robots have also been explored as adjuncts to care. A cluster randomised trial of a robotic seal reported benefits for some indicators of wellbeing relative to usual care (Moyle et al., 2017), and a systematic review and meta-analysis found small positive effects of social robots on older adults, with heterogeneous evidence (Pu et al., 2019). These tools are unlikely to be affordable or sustainable in the most resource-scarce settings and should not displace human contact. Lower-technology options, including mobile messaging, recorded teaching cases, and low-bandwidth tele-mentoring, are more realistic in many contexts.

Table 2. Summary of Selected Evidence on Workforce Preparation and Care Approaches Relevant to Under-Resourced LTC

Approach	Representative evidence	Main findings	Resource implications
Person-centred care training with coaching	Ballard et al. (2018); Kim & Park (2017); Chenoweth et al. (2019)	Improved quality of life and reduced agitation and antipsychotic use in a cluster trial; modest benefit for agitation in a meta-analysis; organisational support is critical	Moderate: coaching time; low equipment cost
Dementia education and training	Surr et al. (2017); Surr & Gates (2017); Rapaport et al. (2017)	Effective programmes are experiential, practice-based, and manager-supported; individualised interventions with ongoing support are more effective	Low to moderate: scalable through workplace delivery
Non-pharmacological interventions	Abraha et al. (2017); Dyer et al. (2018); van der Steen et al. (2018)	Music, massage, behaviour management, and activity-based approaches show promise; certainty of evidence varies	Low: staff time, music, simple activities
Structured interdisciplinary models	Lichtwarck et al. (2018); Kales et al. (2019)	Structured assessment and case conferences improved outcomes; consensus favours non-drug approaches first	Low to moderate: protected team time; some specialist input
Restraint reduction	Möhler et al. (2023)	Evidence is limited and of low certainty; training alone is insufficient without policy and environmental change	Low to moderate: leadership commitment
Environmental modification	Chaudhury et al. (2018)	Homelike, quiet, well-lit, and legible environments are associated with better resident outcomes	Low to high, depending on scale; many changes are inexpensive

Simulation and virtual reality	Hirt & Beer (2020)	Promising for empathy and knowledge; limited evidence of sustained practice change	High: equipment and access
Social robots	Moyle et al. (2017); Pu et al. (2019)	Small benefits for some wellbeing outcomes; heterogeneous evidence	High: purchase, maintenance, and training

A Staged Competency Pathway

To make preparation proportionate to role and resources, Figure 3 proposes a four-stage pathway. Stage 1 provides foundational knowledge and communication skills to all nursing and care staff. Stage 2 develops applied practice for nurses and senior carers, including distress assessment, recognition of delirium and pain, and delivery of non-drug approaches. Stage 3 prepares charge nurses and nurse leaders for case review, medication stewardship, palliative and ethical decision-making, and coaching colleagues. Stage 4 focuses on sustaining and spreading practice through supervision, tele-mentoring, audit, and learning communities. The pathway acknowledges that not every nurse needs advanced training and that a small number of well-supported clinical leaders can multiply the impact of limited resources, provided that the facility creates time and authority for them to lead.

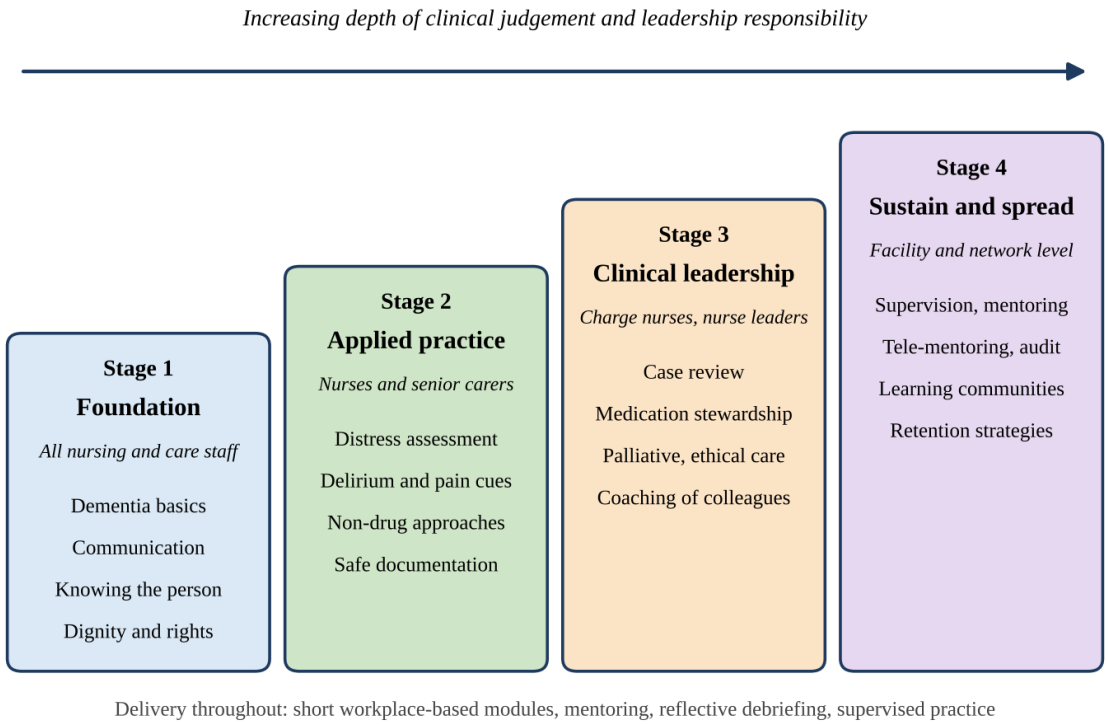


Figure 3. Staged Competency Pathway for Preparing Nurses in Under-Resourced Long-Term Care

Evaluating Learning and Sustaining Change

Evaluation should go beyond attendance and satisfaction to examine whether knowledge, attitudes, behaviour, and resident outcomes change. Because low-resource facilities cannot sustain complex evaluation, a pragmatic approach is to select three or four indicators linked to the competency domains, such as the proportion of residents on regular antipsychotics with a documented review, the number of physical restraints in use, documented pain assessments, and family-reported involvement. Reviewing these indicators monthly at team meetings can create feedback that reinforces learning. The wider literature stresses the importance of manager support and application to real work if effects are to be sustained (Surr & Gates, 2017; Surr et al., 2017), which argues for scheduled refreshers, supervision, and champions within each shift.

Adapting to Cultural and Resource Contexts

Educational content should be adapted to local understandings of ageing and dementia. Where stigma and supernatural explanations are common (Mkhonto & Hanssen, 2018), training should address beliefs directly and respectfully, drawing on community and family perspectives, and include nurses in the design of materials. Given that many LMICs have a high share of dementia risk attributable to modifiable factors (Mukadam et al., 2019), LTC nurses may also contribute to health promotion and early recognition through links with primary care and community health workers. The 2022 World Alzheimer Report emphasised the need for coordinated post-diagnostic care, support, and navigation, suggesting that nurses in LTC are part of a wider continuum that requires training at several levels (Gauthier et al., 2022).

ORGANISATIONAL AND SYSTEM ENABLERS

Leadership, Staffing, and Valuation of the Workforce

Training translates into practice only where leaders protect time, model person-centred values, and respond to staff concerns. Chenoweth et al. (2019) concluded that organisational-level support is central to the implementation of person-centred care. Staffing standards, even if aspirational, provide a benchmark for advocacy (Harrington et al., 2020), and better work environments are associated with lower nurse burnout and missed care (White et al., 2020). Scales (2021) argued that improving wages, creating career ladders, and recognising direct care as skilled work are fundamental to workforce stability. In under-resourced settings, small steps matter, including recognising staff achievements, involving nurses in care decisions, and providing predictable schedules. Without such conditions, investment in education risks being lost through turnover.

Facility leaders can adopt a short list of commitments: protect a defined weekly period for learning or case review, appoint and recognise dementia champions on each shift, make time for handover conversations about residents' emotional states and not only tasks, and involve staff in setting simple targets. Such commitments cost little but signal that the facility values the work, which is itself consistent with evidence linking better work environments to lower burnout among nursing home nurses (White et al., 2019).

Physical and Social Environment

The physical environment influences resident behaviour and nursing workload. A review of the empirical literature found that homelike, small-scale settings, good lighting, reduced noise, legible layouts, and access to outdoor space were associated with better outcomes for residents with dementia (Chaudhury et al., 2018). Many of these modifications, such as reducing noise, improving signage, and creating quiet spaces, are low-cost and can be implemented by nursing staff. Social environments matter equally, including predictable routines, meaningful activity, and opportunities for connection, which align with the person-centred practices described by Fazio et al. (2018).

Family Partnership and Community Resources

Families contribute knowledge of the person that is invaluable for individualised care and are often willing to participate in practical care. Backhaus et al. (2020) found that few interventions to foster family inclusion had been rigorously evaluated, so facilities should develop approaches pragmatically and monitor their effects. In settings where families provide meals, personal care, or companionship, nurses can offer simple training in communication and safe handling, strengthening the care partnership at little cost. Community resources, including faith organisations, volunteers, and students, may also supplement scarce staffing for activities and companionship.

Interprofessional and System-Level Support

Isolated nurses need links to wider systems. The structured interdisciplinary approach of Lichtwarck et al. (2018) demonstrates how regular case conferences can distribute responsibility, even where specialist input is occasional. At the policy level, the global action plan calls for dementia to be treated as a public health priority with workforce training embedded in service planning (World Health Organization, 2017), and the Lancet Commission emphasised multicomponent and coordinated care (Livingston et al., 2020). Governments and funders can support preparation by including LTC in nursing workforce strategies, which the World Health Organization (2022) identifies as requiring investment in education, jobs, and leadership; by setting minimum staffing and training requirements; and by funding regional tele-mentoring or outreach services.

Ethics, Rights, and Accountability

Preparation should also equip nurses to protect the rights of residents who cannot advocate for themselves. This includes understanding capacity and consent, resisting the use of restraint or sedation as a substitute for staffing, and reporting abuse or neglect. Under-resourced conditions can normalise practices that would be unacceptable elsewhere, making ethical reflection essential. Möhler et al. (2023) indicated that reducing physical restraint requires coordinated effort beyond training, while Estabrooks et al. (2020) argued that accountability and transparency are central to restoring trust in LTC. Facilities can embed ethical practice through regular case discussions, clear escalation pathways, and external oversight. Rights-based approaches also support the dignity of nurses, who should not be expected to compensate individually for systemic deficits.

IMPLICATIONS FOR PRACTICE, EDUCATION, POLICY, AND RESEARCH

For practice, facilities should prioritise a small number of high-yield, low-cost routines: structured daily review of residents who show distress, a simple protocol for investigating causes of behavioural change, and scheduled medication review with the nearest available prescriber. Nurse leaders should be supported to coach colleagues and to track a limited set of indicators, such as the use of antipsychotics and restraints, falls, and documented comfort assessments.

For education, undergraduate and postgraduate nursing curricula should include dementia and LTC content that reflects the complexity described here, with clinical placements in LTC that are supervised and valued. In-service programmes should follow the principles of active, practice-based, and manager-supported learning (Surr et al., 2017). Educators in LMICs should co-design content with local clinicians, families, and community leaders.

For policy, the evidence suggests that workforce preparation will not succeed without minimum staffing standards, improved conditions for direct care staff, and accountability for resident outcomes (Estabrooks et al., 2020; Harrington et al., 2020; Scales, 2021). Dementia training requirements should be linked to supervision and career recognition rather than treated as a compliance exercise.

For research, there is a pressing need for implementation studies in LMICs and in under-funded facilities, including pragmatic trials of low-cost training and coaching models, evaluation of tele-mentoring, and studies of the cost-effectiveness of competency pathways. Outcomes should include resident quality of life, prescribing, restraint use, family experience, and staff retention. Research should also examine how cultural beliefs shape nursing practice and how training can address stigma.

LIMITATIONS

This review has several limitations. As a narrative review it is subject to selection bias, and the purposive search may have missed relevant studies, particularly those published in languages other than English or in regional journals. Most trials of non-pharmacological interventions and staff training were conducted in high-income countries and may not transfer directly. The conceptual framework and models are heuristic syntheses rather than validated tools. The evidence on several approaches, including technology-based interventions and restraint reduction, is of low or moderate certainty, and recommendations for under-resourced settings are therefore partly inferential. The competency domains and indicators in Table 1 should be understood as a starting point to be adapted by local clinicians rather than as a standard to be applied uniformly.

CONCLUSION

Preparing the nursing workforce to care for older adults with complex neurocognitive disorders in under-resourced LTC environments is both a clinical and a structural challenge. The evidence supports a competency-based approach that equips nurses to build person-centred relationships, assess and respond to distress, use non-pharmacological care, exercise medication stewardship, provide palliative and family-centred care, and lead their teams. Education that is practice-based, supervised, and embedded in the workplace is more likely to change practice than one-off training, and low-cost strategies can make such preparation feasible. Yet no educational strategy can compensate for chronic understaffing, low workforce status, and fragmented systems. Sustainable progress requires leaders, educators, and policymakers to invest in the workforce and its working conditions alongside training, and researchers to test locally adapted models in the settings where the need is greatest. Ultimately, the quality of life of residents with complex NCDs will depend less on any single programme than on whether nurses are enabled, valued, and supported to practise what they know.

REFERENCES

[1] Abraha, I., Rimland, J. M., Trotta, F. M., Dell'Aquila, G., Cruz-Jentoft, A., Petrovic, M., ... & Cherubini, A. (2017). Systematic review of systematic reviews of non-pharmacological interventions to treat behavioural disturbances in older patients with dementia. The SENATOR-OnTop series. BMJ open, 7(3), e012759.

[2] Babulal, G. M., Zha, W., Trani, J. F., Guerra, J. L., Tee, B. L., Zhu, Y., ... & Diversity and Disparity Professional Interest Area, Low-and-Middle-Income Working Group. (2024). Identifying gaps and barriers in Alzheimer's disease and related dementia research and management in low-and middle-income countries: a survey of health professionals and researchers. Journal of Alzheimer's Disease, 101(4), 1307-1320.

[3] Backhaus, R., Hoek, L. J., de Vries, E., van Haastregt, J. C., Hamers, J. P., & Verbeek, H. (2020). Interventions to foster family inclusion in nursing homes for people with dementia: a systematic review. BMC geriatrics, 20(1), 434.

[4] Ballard, C., Corbett, A., Orrell, M., Williams, G., Moniz-Cook, E., Romeo, R., ... & Fossey, J. (2018). Impact of person-centred care training and person-centred activities on quality of life, agitation, and antipsychotic use in people with dementia living in nursing homes: A cluster-randomised controlled trial. PLoS medicine, 15(2), e1002500.

[5] Cations, M., Laver, K. E., Crotty, M., & Cameron, I. D. (2018). Rehabilitation in dementia care. Age and ageing, 47(2), 171-174.

[6] Chaudhury, H., Cooke, H. A., Cowie, H., & Razaghi, L. (2018). The influence of the physical environment on residents with dementia in long-term care settings: A review of the empirical literature. The Gerontologist, 58(5), e325-e337.

[7] Chenoweth, L., Stein-Parbury, J., Lapkin, S., Wang, A., Liu, Z., & Williams, A. (2019). Effects of person-centered care at the organisational-level for people with dementia. A systematic review. PloS one, 14(2), e0212686.

[8] Costello, H., Walsh, S., Cooper, C., & Livingston, G. (2019). A systematic review and meta-analysis of the prevalence and associations of stress and burnout among staff in long-term care facilities for people with dementia. International psychogeriatrics, 31(8), 1203-1216.

[9] Dewing, J., & McCormack, B. (2017). Tell me, how do you define person-centredness?.

[10] Dyer, S. M., Harrison, S. L., Laver, K., Whitehead, C., & Crotty, M. (2018). An overview of systematic reviews of pharmacological and non-pharmacological interventions for the treatment of behavioral and psychological symptoms of dementia. International psychogeriatrics, 30(3), 295-309.

[11] Estabrooks, C. A., Straus, S. E., Flood, C. M., Keefe, J., Armstrong, P., Donner, G. J., ... & Wolfson, M. C. (2020). Restoring trust: COVID-19 and the future of long-term care in Canada. Facets, 5(1), 651-691.

[12] Fazio, S., Pace, D., Flinner, J., & Kallmyer, B. (2018). The fundamentals of person-centered care for individuals with dementia. The gerontologist, 58(suppl_1), S10-S19.

[13] Ferri, C. P., & Jacob, K. S. (2017). Dementia in low-income and middle-income countries: different realities mandate tailored solutions. PLoS medicine, 14(3), e1002271.

[14] Gauthier, S., Webster, C., Servaes, S., Morais, J. A., & Rosa-Neto, P. (2022). Life after diagnosis: navigating treatment, care and support. Alzheimer's disease international World Alzheimer Report, 2022, 1-414.

[15] Harrington, C., Dellefield, M. E., Halifax, E., Fleming, M. L., & Bakerjian, D. (2020). Appropriate nurse staffing levels for US nursing homes. Health services insights, 13, 1178632920934785.

[16] Hirt, J., & Beer, T. (2020). Use and impact of virtual reality simulation in dementia care education: A scoping review. Nurse education today, 84, 104207.

[17] Kales, H. C., Lyketsos, C. G., Miller, E. M., & Ballard, C. (2019). Management of behavioral and psychological symptoms in people with Alzheimer's disease: an international Delphi consensus. International psychogeriatrics, 31(1), 83-90.

[18] Kim, S. K., & Park, M. (2017). Effectiveness of person-centered care on people with dementia: a systematic review and meta-analysis. Clinical interventions in aging, 381-397.

[19] Lichtwarck, B., Selbaek, G., Kirkevold, Ø., Rokstad, A. M. M., Benth, J. Š., Lindstrøm, J. C., & Bergh, S. (2018). Targeted interdisciplinary model for evaluation and treatment of neuropsychiatric symptoms: a cluster randomized controlled trial. The American Journal of Geriatric Psychiatry, 26(1), 25-38.

[20] Livingston, G., Huntley, J., Sommerlad, A., Ames, D., Ballard, C., Banerjee, S., ... & Mukadam, N. (2020). Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. The lancet, 396(10248), 413-446.

[21] Livingston, G., Sommerlad, A., Orgeta, V., Costafreda, S. G., Huntley, J., Ames, D., ... & Mukadam, N. (2017). Dementia prevention, intervention, and care. The lancet, 390(10113), 2673-2734.

[22] Maust, D. T., Strominger, J., Kim, H. M., Langa, K. M., Bynum, J. P., Chang, C. H., ... & Marcus, S. C. (2021). Prevalence of central nervous system–active polypharmacy among older adults with dementia in the US. Jama, 325(10), 952-961.

[23] McGilton, K. S., Escrig-Pinol, A., Gordon, A., Chu, C. H., Zúñiga, F., Sanchez, M. G., ... & Bowers, B. (2020). Uncovering the devaluation of nursing home staff during COVID-19: are we fuelling the next health care crisis?. Journal of the American Medical Directors Association, 21(7), 962-965.

[24] Mkhonto, F., & Hanssen, I. (2018). When people with dementia are perceived as witches. Consequences for patients and nurse education in South Africa. Journal of clinical nursing, 27(1-2), e169-e176.

[25] Möhler, R., Richter, T., Köpke, S., & Meyer, G. (2011). Interventions for preventing and reducing the use of physical restraints in long-term geriatric care. Cochrane Database of Systematic Reviews, (2).

[26] Moore, K. J., Sampson, E. L., Kupeli, N., & Davies, N. (2020). Supporting families in end-of-life care and bereavement in the COVID-19 era. International psychogeriatrics, 32(10), 1245-1248.

[27] Moyle, P. W., Jones, P. C. J., Thalib, P. L., Beattie, P. E. R., Shum, P. D. K., O'Dwyer, P. S. T., ... & Draper, M. B. M. (2017). Use of a robotic seal as a therapeutic tool to improve dementia symptoms: a cluster-randomized controlled trial. Journal of the American Medical Directors Association, 18(9), 766-773.

[28] Mukadam, N., Sommerlad, A., Huntley, J., & Livingston, G. (2019). Population attributable fractions for risk factors for dementia in low-income and middle-income countries: an analysis using cross-sectional survey data. The Lancet Global Health, 7(5), e596-e603.

[29] Nichols, E., Steinmetz, J. D., Vollset, S. E., Fukutaki, K., Chalek, J., Abd-Allah, F., ... & Liu, X. (2022). Estimation of the global prevalence of dementia in 2019 and forecasted prevalence in 2050: an analysis for the Global Burden of Disease Study 2019. The Lancet Public Health, 7(2), e105-e125.

[30] Oh, E. S., Fong, T. G., Hshieh, T. T., & Inouye, S. K. (2017). Delirium in older persons: advances in diagnosis and treatment. Jama, 318(12), 1161-1174.

[31] Pu, L., Moyle, W., Jones, C., & Todorovic, M. (2019). The effectiveness of social robots for older adults: a systematic review and meta-analysis of randomized controlled studies. The gerontologist, 59(1), e37-e51.

[32] Rapaport, P., Livingston, G., Murray, J., Mulla, A., & Cooper, C. (2017). Systematic review of the effective components of psychosocial interventions delivered by care home staff to people with dementia. BMJ open, 7(2), e014177.

[33] Sampson, E. L., Candy, B., Davis, S., Gola, A. B., Harrington, J., King, M., ... & Jones, L. (2018). Living and dying with advanced dementia: a prospective cohort study of symptoms, service use and care at the end of life. Palliative medicine, 32(3), 668-681.

[34] Scales, P. K. (2022). Transforming direct care jobs, reimagining long-term services and supports. Journal of the American Medical Directors Association, 23(2), 207-213.

[35] Scales, K., Zimmerman, S., & Miller, S. J. (2018). Evidence-based nonpharmacological practices to address behavioral and psychological symptoms of dementia. The Gerontologist, 58(suppl_1), S88-S102.

[36] Surr, C. A., & Gates, C. (2017). What works in delivering dementia education or training to hospital staff? A critical synthesis of the evidence. International journal of nursing studies, 75, 172-188.

[37] Surr, C. A., Gates, C., Irving, D., Oyebode, J., Smith, S. J., Parveen, S., ... & Dennison, A. (2017). Effective dementia education and training for the health and social care workforce: a systematic review of the literature. Review of educational research, 87(5), 966-1002.

[38] Van der Steen, J. T., van der Wouden, J. C., Methley, A. M., Smaling, H. J., Vink, A. C., & Bruinsma, M. S. (2025). Music-based therapeutic interventions for people with dementia. Cochrane database of systematic reviews, (3).

[39] White, E. M., Aiken, L. H., & McHugh, M. D. (2019). Registered nurse burnout, job dissatisfaction, and missed care in nursing homes. Journal of the American Geriatrics Society, 67(10), 2065-2071.

[40] White, E. M., Aiken, L. H., Sloane, D. M., & McHugh, M. D. (2020). Nursing home work environment, care quality, registered nurse burnout and job dissatisfaction. Geriatric Nursing, 41(2), 158-164.

[41] World Health Organization. (2017). Global action plan on the public health response to dementia 2017–2025. World Health Organization.

[42] World Health Organization. (2022). The nursing and midwifery workforce in the African Region: optimizing and accelerating investments for resilient health systems: a regional technical report.

[43] World Health Organization. (2021). Global status report on the public health response to dementia: web annex: methodology for producing global dementia cost estimates. World Health Organization.

إعداد القوى العاملة التمريضية لرعاية كبار السن المصابين باضطرابات عصبية معرفية معقدة في بيئات الرعاية طويلة الأجل محدودة الموارد: مراجعة سردية

الملخص

يُعدّ التمريض محوريًا في تقديم الرعاية الشخصية المركزة لمرضى الخرف، غير أنّ كبار السن المصابين باضطرابات عصبية معرفية (NCDs) معقدة يعيشون بشكل متزايد في بيئات الرعاية طويلة الأجل حيث تكون الكوادر قليلة، والتدريب محدود، والموارد شحيحة. تُجمّع هذه المراجعة السردية الأدبيات المنشورة بين عامي 2017 و2024 حول كيفية إعداد القوى العاملة التمريضية لتقديم رعاية آمنة ومتمحورة حول الشخص في هذه البيئات. وتشير الأدلة إلى أنّ التعقيد ينشأ من تفاعل الأعراض السلوكية، والهذيان، والألم، وتعدد الأمراض، واحتياجات نهاية الحياة مع القيود التنظيمية. ويجمع الإعداد الفعّال بين الكفايات الأساسية، والتعلم القائم على الممارسة والتعلم المُشرف عليه، والنهج غير الدوائية المنظّمة، والممكّنات التنظيمية مثل القيادة، والشراكة مع الأسرة، والبيئات الداعمة. وتُقترح إطارًا مفاهيميًا، ونموذج استجابة متعدد المستويات، ومسارًا مرحليًا للكفايات التمريضية. وتشير النتائج إلى أنّ التعليم منخفض التكلفة والمدمج في مكان العمل يحسّن الممارسة بشكل موثوق فقط عندما يقترن بتقدير قيمة القوى العاملة، وكفاية الكوادر، والاستثمار المستدام في النظام. وتُحدَّد أولويات السياسات والممارسة والتعليم والبحث وتُناقَش.

الكلمات المفتاحية :الخرف؛ الاضطرابات العصبية المعرفية؛ الرعاية طويلة الأجل؛ القوى العاملة التمريضية؛ البيئات محدودة الموارد.