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ORIGINAL ARTICLE

Dementia care in Nepalese old age homes: Critical challenges as perceived by healthcare professionals

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Abstract

Aim: To explore and describe critical challenges in current dementia care practice as perceived by healthcare professionals (HCPs) in old age homes (OAHs) in Kathmandu, Nepal.

Background: In Nepal, the number of older people with dementia is rapidly rising, and there is a need for knowledge of how to provide quality dementia care in OAHs.

Methods: An exploratory hermeneutic design, employing qualitative interviews with eleven HCPs caring for residents with dementia in a total of five OAHs.

Findings: The analysis showed that HCPs found limited educational training in dementia-specific care to be a critical challenge leading to reduced quality in caregiving practice. Insufficient HCP competence in dementia-specific care undermined adequate coping with residents' cognitive disturbances and the behavioural and psychological symptoms in dementia (BPSD). Poor HCP/medical doctor (MD)-to-patient ratio was perceived as a critical challenge preventing proper diagnostic examination, treatment and dementia-specific care practice.

Conclusions: Limited educational training, sparse competence in mastering residents' cognitive disturbances and BPSD, and insufficient resources to ensure sufficient numbers of HCPs and MDs for proper diagnostic examination, treatment and dementia-specific care were identified as critical challenges restricting quality dementia care in these Nepalese OAHs.

Implications for practice: The study findings indicate a need for a clear Nepalese policy and a national plan for dementia care in OAHs that includes strategies for HCP educational training and how to provide resources to ensure a sufficient workforce of HCPs and MDs for proper diagnostic examination, treatment and dementia-specific care.

KEYWORDS
behavioural and psychological dementia symptoms, dementia care, healthcare professionals, knowledge and competence, medical doctors, old age homes, resources

1 | INTRODUCTION

Knowledge of challenges hindering quality care for persons living with dementia and strategies on how to overcome such obstacles is of interest for the international community of gerontological nurses and allied healthcare professionals. According to the World Health Organization (WHO, 2021), dementia is an emerging challenge for public health associated with morbidity and mortality among those affected. The international community of older people nursing should, therefore, explore and describe current dementia care practices and how these can be improved. Worldwide, dementia syndrome is one of the major causes of disability and dependency among older people. Dementia is more prevalent among people aged over 65 years, as the risk of dementia illness increases with age and comorbidities, leading to a deterioration in cognitive functions like memory, thinking, orientation and ability to perform everyday activities (WHO, 2021). Moreover, *behavioural and psychological symptoms of dementia* (BPSD) is an umbrella term describing symptoms that frequently occur in persons with dementia (Finkel et al., 1996) and includes perceptual, emotional and behavioural disturbances that can be classified in five domains: 'cognitive/perceptual (delusions, hallucinations), motor (e.g., pacing, wandering, repetitive movements and physical aggression), verbal (e.g., yelling, calling out, repetitive speech and verbal aggression), emotional (e.g., euphoria, depression, apathy, anxiety and irritability) and vegetative (disturbances in sleep and appetite)' (Cloak & Al Khalili, 2020). These latter disturbances are often more troubling for the person living with dementia than cognitive disturbances like memory loss and problems with orientation (Press & Alexander, 2014).

Worldwide, around 55 million people are living with dementia, of whom more than 60% are living in low- and middle-income countries (LMIC) (WHO, 2021). The quality of healthcare services for people with dementia is presently insufficient (Prince et al., 2016), while the prevalence of dementia in LMIC is rapidly increasing. Dementia is often perceived as part of the ageing process, and therefore, many never receive a dementia diagnosis. Diagnostic examination, treatment and care for those with dementia pose a complex and challenging task in LMIC (Ferri & Jacob, 2017).

1.1 | Background

In Nepal, forgetfulness among older people is considered a normal part of ageing, and there is no definite term for dementia or Alzheimer's disease in the Nepali language. Symptoms of dementia are, therefore, often not recognised as symptoms of a disease requiring medical attention and care, rather perceiving people with dementia as persons who have 'lost their mind' and being treated as psychiatric patients. There is a stigma associated with mental disorder in Nepalese society. The fear of being excluded and no longer being treated as an equal member of society exists among these patients' relatives. This concern affects their help-seeking behaviours and hampering the actual data on the disease's prevalence in the country (Koirala, 2016).

Healthcare services for people with dementia in Nepal are sparse. Skilled manpower and healthcare facilities are limited (Koirala, 2016). Most healthcare services are organised as private

SUMMARY STATEMENT OF IMPLICATIONS FOR PRACTICE

What does this research add to existing knowledge in gerontology?

- Limited educational training of healthcare professionals and staff in Nepalese old age homes hinders quality care for residents with dementia.
- Insufficient HCP competence in dementia-specific care undermines adequate coping with these residents' cognitive disturbances and behavioural and psychological symptoms.
- Poor healthcare professional/medical doctor-to-patient ratio prevents diagnostic examination, treatment and dementia-specific care for people with dementia.

What are the implications of this new knowledge for nursing care with older people?

- Healthcare professionals' limited educational training and insufficient coping in providing dementia-specific care should be brought to an end.
- How to develop quality dementia-specific care practices should be explicitly addressed in the curriculum for healthcare professionals.
- Appropriate healthcare professional/medical doctor-to-patient ratio should be emphasised to ensure diagnostic examination, treatment and dementia-specific care for people with dementia.

How could the findings be used to influence policy or practice or research or education?

- A coordinated national dementia care plan should be developed that also includes strategies for healthcare professionals' dementia-specific care education and how to facilitate a knowledge translation culture in healthcare for people living with dementia.
- The findings can be used to progressively improve the coherence between national strategies for education, health, finance and labour, and the employment of a health workforce consisting of healthcare professionals and medical doctors—whose numbers and competence are adequate to ensure diagnostic examination, treatment and dementia-specific care.

enterprises (Koirala, 2016; Sapkota & Subedi, 2019). However, there are no specialised healthcare services designed for diagnosing dementia, and psychiatric hospitals and old age homes (OAHs) are the only healthcare services available for this patient group today (Pathak & Montgomery, 2015; Sapkota & Subedi, 2019). Nepalese nursing homes (NHs) and OAHs provide different healthcare services. NHs are usually profit-based private institutions and are smaller than hospitals. They have a variety of clinical care services, including outpatient department, intensive care unit / operation theatre ward, general ward, emergency ward, medical ward, gynaecological ward, orthopaedic ward, paediatric ward and psychiatric ward (Pathak & Gaire, 2020). OAHs, on the other hand, have historically been established as residential homes for older people that have no family to take care of them. Today, the number of older people living in the OAHs is increasing due to the growing trend of youth migration to urban areas and foreign countries, urbanisation and the changing structure of family households (Chalise, 2014). As a consequence of the societal changes, residing in an OAH often is the only option for older people when developing a need for care and support (Khanal et al., 2018). Government OAHs are funded by the government and by donations from various voluntary organisations and individuals in Nepal and abroad. Basically, government OAHs provide housing, sanitation, clothing, healthcare, pilgrimage, religious and entertainment programmes and organising funerals and traditional death anniversary celebrations (Shrestha, 2006). Private OAH admission is usually paid by residents' families, and these OAHs have better healthcare services, dwelling units and other facilities (Mishra & Chalise, 2018). The criteria for residents' admission vary depending on the types of OAHs. In the government OAHs, the criteria for admission are having a Nepalese citizenship certificate, being 65 years or older and having a clear recommendation letter from the concerned village Development Committee or Municipality stating that the person is poor and has no family/other caregivers that can provide the necessary care. To become an OAH resident, a formal application must be directed to the Ministry of Women, Children and Social Welfare (Shrestha, 2006). Admission criteria of the semiprivate OAH included in this study were people above 60 years with Nepali citizenship, who are dependent, poor, having no family or whose families are unwilling to take care of them. In addition, applicants must not have any mental illness or disability or communicable disease at the start of the application process. The private OAH admission criteria were older people in need of nursing and geriatric care, including care for persons with specific diseases like Alzheimer's disease and related dementia, and having family members willing to pay for such residential care.

Research is needed to better understand the critical challenges of current dementia care practice in Nepalese OAHs, as few studies have been conducted so far. In a study conducted in the context of dementia care in OAHs, Khanal and Gautam (2011) found that most of the staff deployed in OAHs in Kathmandu had never attended any professional training in order to learn the basic principles of dementia care. HCPs are the gatekeepers of the healthcare system. Due to their position, HCPs responsible for daily dementia care have a unique experience of the current critical challenges that may counteract the insufficient quality of dementia care. Such knowledge can be used by Nepalese policymakers and organisations responsible for OAHs in their efforts to develop quality residential dementia care.

1.2 | Aim

The aim of this study was to explore and describe critical challenges in current dementia care practice as perceived by HCPs in OAHs in Kathmandu, Nepal.

2 | METHOD

2.1 | Study design

An exploratory qualitative design was used since this is an appropriate approach for exploring and understanding the meaning that individuals or groups ascribe to a social or human challenge (Creswell & Creswell, 2017). The hermeneutical methodology was chosen as the epistemological foundation of the study (Fleming et al., 2003; Gadamer, 2004), which is a relevant methodology for exploring what caring means in a particular context (Spichiger et al., 2005). Hermeneutics is the study of the interpretation of texts to obtain a valid and common understanding of their meaning (Brinkmann & Kvale, 2015; Fleming et al., 2003). Following the five-step process for conducting hermeneutic research in nursing, recommended by Fleming et al. (2003), we first focused on *deciding upon a question*, to ensure the appropriateness of the research question (formulated above) in relation to the underpinning methodology of the study. This is vital to provide internal consistency of the process of expanding knowledge in the discipline of nursing. Second, we explored and described our beforehand assumptions related to the question addressed to promote the *identification of preunderstandings*. Our preunderstandings will be presented below, under the heading 2.2 Preunderstanding. *Gaining understanding through dialogue with participant*, *gaining understanding through dialogue with text* and *establishing trustworthiness* are the three last steps of the hermeneutical research process (Fleming et al., 2003) and will be described below in 2.3 Participants and recruitment, 2.4 Data collection and 2.5 Data analysis, respectively.

2.2 | Preunderstanding

The second step of the hermeneutical research process is as follows—the researchers' *identification of preunderstandings* is important since preunderstandings are a prerequisite for understanding something new. Bringing our preunderstandings into consciousness and reflecting upon these beforehand assumptions help us to move beyond these taken-for-granted perceptions of the phenomena under investigation (Fleming et al., 2003; Gadamer, 2004). Researchers'

preunderstanding (Gadamer et al., 2004) should also be presented to the reader to make the interpretive context available and increase study transparency (Hiles & Čermák, 2007) and trustworthiness (Guba & Lincoln, 1994; Lincoln & Guba, 1985; Polit & Beck, 2010). Our preunderstanding was based on the assumption that HCPs in OAHs in Nepal do experience professional challenges in their daily care for residents with dementia. We believed that HCPs held a key role in the promotion of quality care for this patient group, and we were uncertain what their level of education in dementia care was. We were open to the possibility that current care was knowledge based, but we assumed that practices were essentially experience based. We expected that a restricted workforce might be a central issue and that understanding HCPs' perceptions would enable us to document both critical challenges and potentials for improving dementia care practices in Nepalese OAHs.

2.3 | Recruitment and participants

In the third step of the hermeneutical research process, *gaining understanding through dialogue with participants* (Fleming et al., 2003), a purposeful sampling strategy (Creswell & Creswell, 2017; Polit & Beck, 2010) was used to recruit HCP caring for OAH residents with dementia. Nurses and physiotherapists were selected because of their central roles in daily dementia care. Physiotherapists in OAHs plan and conduct exercises and activities based on the ability and mobility status of the residents with dementia, to prevent and/or alleviate musculoskeletal pain and stimulate metabolism and blood circulation. Similar to nurses, physiotherapists also put emphasis on informing residents of time and place and encouraging conversation about their life stories. Only some private OAHs provide physiotherapy services to meet their residents' needs for physical treatment plans, whereas in other OAHs the residents are provided with more simple forms of exercises led by nurses and other staff, such as taking them for walk around the premises of OAHs, usually on daily basis.

For selecting OAHs for inclusion, convenience sampling (Creswell & Creswell, 2017; Polit & Beck, 2010) was chosen, and the OAHs selected included one governmental, one semi-private and three private OAHs in Kathmandu, as their managers consented to our request for study participation. With the assistance of the OAH managers, eleven HCPs, that is two nurses from government OAH, one nurse from semi-private OAH, and six nurses and two physiotherapists from private OAHs, were recruited as study participants based on the following inclusion criteria: has a formal education as a HCP and at least 6 months of experience of daily care for OAH residents with dementia (**Table 1**).

2.4 | Data collection

In the process of *gaining understanding through dialogue with participants* (Fleming et al., 2003), in-depth interviews (Brinkmann & Kvale, 2015) were chosen as data collection tools as these allow the opportunity for genuine dialogues with the study participants. Examples of questions guiding our conversations were as follows: *During your professional education, what did you learn about dementia and dementia care? How do you update yourself about ongoing research and seminars about dementia care? If you get an opportunity to attend training for dementia care—what would you like to learn?* Being open, engaged and explorative, and conscious of own preunderstandings in the dialogue with each participant (Fleming et al., 2003) helped us develop a deeper understanding of the phenomenon under investigation. The interviews were carried out by the first author (SS), and all were conducted within the OAH facilities. All participants were asked to participate in a follow-up interview, and four of them gave their consent. The follow-up interviews gave us the opportunity to discuss and validate our preliminary interpretation of the first eleven interviews and to investigate new perceptions of critical challenges that the participants had become aware of since the first interview. All interviews were scheduled

TABLE 1 Details of participants

Participants	Education	Profession
1	Proficiency certificate level (PCL) nursing	Nurse
2	Proficiency certificate level (PCL) nursing	Nurse
3	Auxiliary nursing midwife (ANM)	Nurse
4	Bachelor in Nursing Hospitality and Management	Nurse and medical counsellor
5	Proficiency certificate level (PCL) nursing Bachelor in Nursing	Nurse
6	Bachelor and Master in Physiotherapy	Physiotherapist
7	Proficiency certificate level (PCL) nursing	Nurse
8	Proficiency certificate level (PCL) nursing	Nurse
9	Bachelor and Master in Physiotherapy	Physiotherapist
10	Proficiency certificate level (PCL) nursing, Bachelor in Nursing	Charge Nurse
11	Proficiency certificate level (PCL) nursing	Nurse

for 60–90 min, but some of the interviews were shorter, as the interviews were conducted within the OAH facility during the HCPs' working hours and some participants had to return to their caregiving duties earlier than scheduled. All interviews were conducted in the Nepali language, tape recorded and transcribed verbatim in English for hermeneutical text analysis. The first author, a native speaker of the Nepali language with English language proficiency, transcribed the interviews—making the interview data in Nepalese understandable for the English-speaking second author and making it possible to share the Nepalese HCPs perceptions as formulated by themselves, in a journal read by the international community of older people nursing.

2.5 | Data analysis

The notion of dialogue does also include the reader's conversation with the text. Questioning and reassessing a text about the meaning of a certain phenomenon are a circular process of growing ideas termed 'hermeneutic circles' (Fleming et al., 2003; Gadamer et al., 2004). Every time the researcher re-explores the text, new possibilities may emerge for a deeper understanding of its content (Fleming et al., 2003; Gadamer et al., 2004). Thus, in the fourth step of this research process, we emphasised *gaining understanding through dialogue with the text* (Fleming et al., 2003). Each transcribed interview was read several times in order to gain a deeper understanding of each text. During each reading, keywords and important phrases were noted, and our first preliminary interpretations were written down. The initial interpretations of each interview were then discussed by us as researchers to clarify differences and similarities in our interpretive understanding and develop a common, initial overall understanding of the data. In the next step, each sentence and each paragraph of each interview text were investigated in order to expose its deeper meaning. During this hermeneutical circular process, we as researchers went back and forth in each interview text to explore the parts and the text as a whole. In this series of actions, we critically investigated other possible interpretations of the parts and the whole so as to let the substance of the text come forward and prevent our preunderstanding from concealing its essence. This process facilitated our final identification and understanding of the critical challenges in current OAH dementia care.

Importantly, the fifth step of the hermeneutical research process—*establishing trustworthiness*, is an ongoing process during the whole research process (Fleming et al., 2003). In this process, we used the COREQ checklist (Tong et al., 2007) to promote comprehensive reporting from this qualitative study. Additionally, the criteria of research credibility, dependability, confirmability, transferability and authenticity (Guba & Lincoln, 1994; Lincoln & Guba, 1985) were followed. We performed reflexive journaling during planning, data collection and data analysis to enhance study credibility. We put emphasis on providing transparent documentation of the research process in order to strengthen study dependability. We sought confirmability by carefully documenting all of the information shared by the HCPs while simultaneously reflecting upon our preunderstandings to prevent interpretive bias. Accordingly, in the analysis process we sought for empirical data in our data material that could disconfirm our preliminary interpretations—in order to identify other possible interpretations of the data. To heighten transferability, we collected a sufficient amount of data to establish a sound description of the HCPs' perceptions, and emphasis was given to portraying the HCPs' perceptions as they themselves expressed them so as to strengthen study authenticity.

2.6 | Ethical considerations

This study was approved by the Nepal Health Research Council. Permission to conduct interviews was separately sought from each OAH. The manager of each OAH received both verbal and written information about the study and gave their approval for the study to be performed. In line with the Declaration of Helsinki (World Medical Association, 2013), informed consent was gained from each participant after they had received verbal and written information about the study, including their right to withdraw without any consequences.

3 | RESULTS

During the analysis, three themes emerged describing HCPs' perceptions of the critical challenges in current dementia care in Nepalese OAHs (Figure 1).

3.1 | Limited educational training interfering with the quality of dementia-specific care

First, the HCPs found limited educational dementia care training to be a critical challenge leading to the reduced quality of dementia care. Having sufficient knowledge about dementia syndrome, attitudes and care interventions was perceived as a critical basis for providing quality dementia care. They expressed the concern that their care practice was largely based on personal experience, individual skills and preferences, and not on professional standards, as their educational training and knowledge of this patient group were limited. They highlighted the importance of having adequate professional knowledge to understand underlying causes and appropriate care interventions—a curriculum for theoretical and practical competence in dementia illness and dementia care.

> First of all, there are just two nurses working here on a daily basis and we have not learnt much about dementia. We have no theoretical knowledge about how to behave with people with dementia or how to care for them so that they are satisfied. We have created our

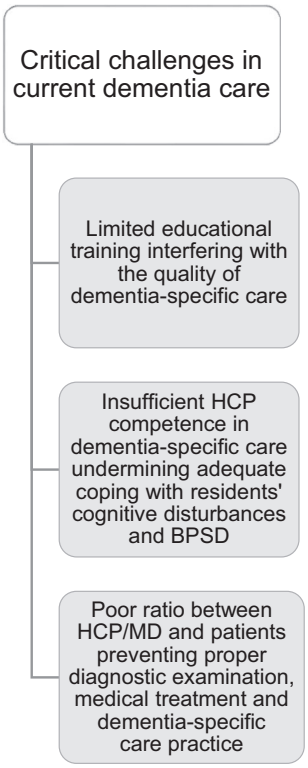

FIGURE 1 Critical challenges in current dementia care

> own culture for how to care for people with dementia based on our personal experience and understanding. We have not studied any special course on this. There should be special training for this. We have had some psychiatric courses during our studies but nothing specific on dementia
>
> (Nurse, Government OAH).

Having limited knowledge of how to perform dementia-specific care, the HCPs tried to use their common sense and experience, hoping for a good outcome for their residents. However, they were often uncertain whether they handled given care situations in the best possible way, and this gave rise to ethical concern. Most of them underlined a need to ensure that their dementia care practice was in line with professional practice as described in updated literature and guidelines.

> Over here, there are many dementia cases. If we had better training, we could understand more about how to treat them and care for them. We do not have such special training for dementia cases, so we just provide general care for them as we do for other patients. If we had training, then we could better understand the behaviours and more
>
> (Nurse, private OAH).

Most HCPs showed positive attitudes towards educational training, which could help them provide dementia-specific care and not what they referred to as 'general care'.

3.2 | Insufficient HCP competence in dementia-specific care undermining adequate coping with residents' cognitive disturbances and BPSD

Second, it was the HCPs' experience that their sparse foundation for practicing dementia-specific care made it difficult for them to cope with the residents' cognitive disturbances and BPSD in a professional way. Mastering the residents' forgetfulness, aggression, mood swings and repetitive behaviours were recognised as being the most challenging. The HCPs often strived to find the right words and the necessary instructions in order to establish adequate communication and sound relational interaction with these residents.

> It is very difficult to handle them. They forget things and try to do things the way they want. Sometimes, when we stop them from doing the things they want, they get angry. They leave the OAH, go out in the road saying that they have work to do. We need to bring them back and sometimes we need to put them inside their room. In this context, having a positive attitude does not work. Sometimes, it's like we have no option but to behave in negative ways
>
> (Nurse, Government OAH).

When expressing 'it's like we have no option but to behave in negative ways', the staff were especially referring to the use of isolation, to letting residents stay inside their room and to situations where staff instructed residents in ways that can be perceived as unprofessional, negative and inappropriate coping with what they experienced a challenging' behaviour of residents with dementia. Another nurse expressed it like this:

> I feel irritated or my mind goes blank while continuously taking care of them, we need to say same things repetitively. Telling them one thing 3–4 times is not enough, we need to tell them 5-10 times. There is one resident who has difficulty in following what we instruct even if we say several times.
>
> (Nurse Private OAH)

At such instances, HCPs described how they sometimes became irritated and how this emotional reaction could negatively affect their professional communication with residents, resulting in what they felt was bad-mannered behaviour of them as HCP caring for vulnerable residents with dementia.

Residents' forgetfulness due to dementia was also a major challenge while providing physiotherapy, as these residents had difficulties in making progress due to their tendency to forget the exercises they previously had performed. These residents were reported to have pain related to problems with their joints and back, and some of the wheelchair-bound residents had problems related to joint stiffness. According to the physiotherapists, these residents were

in need of active or passive ranges of exercises depending on their ability and their condition, and as professionals, the physiotherapists felt a growing need for better coping strategies to help maintain the physical mobility of this patient group.

> The biggest challenge is the memory loss itself, because in physiotherapy, if the patient is really involved in the exercise, then the chance for progress in the recovery process increases. In these cases, although we have been continuously providing them with physiotherapy classes and exercises – active exercise to those who can do these on their own, and passive types of exercise, like stretching, to those who are wheel chair bound and need assistance, (but) they tend to forget the exercises, which makes it difficult for us to move forward and make more progress
>
> (Physiotherapist, Private OAH).

Another critical challenge was residents refusing to take their prescribed medication. Common behaviour in such situations included throwing out medicine, spitting it out or hiding it in pockets. To ensure that the residents received their vital prescribed oral medicine, HCPs often felt forced to hide the medicine in residents' food, for example by grinding pills into a paste and mixing it into food, milk or water.

> When they are told to take their medicine, they are often unwilling to do so. Some throw it away, some put it in their pockets, and some put it in their glass. None of them take the medicine when we give them this in their hands. Suddenly they grab it out of our hands and then chew the medicine and they find it bitter and spit it out. So, we have to hide the pills in food to ensure that they get their vital medication
>
> (Nurse, Private OAH).

However, the HCPs perceived this as an ethical dilemma and a practice of administering medicine that they would prefer to avoid, arguing that they would benefit from improved professional competence and coping related to the ethical and juridical issues of dementia-specific care practice.

3.3 | Poor ratio between HCP/MD and patients preventing proper diagnostic examination, medical treatment and dementia-specific care practice

Third, the HCPs emphasised that being continuously short of HCPs and MDs at the OAHs prevented proper diagnostic examination, treatment and quality care for this patient group. When interviewing them about their OAH staffing ratios, we found that it did vary among the different facility types, for example that it was comparatively higher among the private OAHs than the government OAH. At the time of interviews, the nurse-resident ratio for the private OAHs was reported to be 9–10:1, that is one nurse for every 9–10 residents on both day and night shifts. In the semi-private OAH, this ratio was 39:1, and in the government OAH, the ratio was reported to be 175:1. Additionally, each OAH had unskilled assistants responsible for maintaining personal hygiene and sanitation of residents, cooking, cleaning and assisting HCPs in providing recreational activities. Nursing student volunteers did sometimes assist the HCPs in government and semi-private OAHs in organising recreational activities and conducting regular health check-up programmes for their residents.

Participants argued that the number of HCPs was not sufficient to ensure proper treatment and care for all residents with dementia and undiagnosed signs of cognitive impairment. The HCPs also perceived the diagnostic examination practice for this patient group as being deficient and voiced a need for an increased level of specialist consultation for diagnostic examination, treatment and follow-up.

> Actually, there are no specific diagnosed cases of dementia as they have not been properly diagnosed, but symptoms such as forgetfulness and communicating randomly in incomprehensible ways that are difficult for us to understand, are some symptoms indicating that they might have dementia
>
> (Nurse, Government OAH).

Another HCP concern was what they perceived as sparse access to general medical services for these OAH residents.

> I think the (medical) care we have been giving them is not good enough, because they need hospital-based care and other things, but here the doctors come and do the follow-ups, write the prescriptions. We give them those medications. I think the care we have been providing to them is not enough
>
> (Nurse, Government OAH).

Equal access to proper medical examination and treatment for painful conditions was given as an example, and participants underlined the need for quality assessment and treatment related to the residents' dementia syndrome and to existing comorbidities.

> One of the main problems of many of our patients is related to joint pain for which they require physiotherapy, and the treatment for dementia patients is not well managed. And also, for other existing co-morbidities, they need ECG, x-ray – for which they should be taken to the hospital for a thorough investigation
>
> (Nurse, Government OAH).

Due to the shortage of staff with adequate training, the HCPs labelled the care given to residents with dementia as 'general care' rather than 'dementia care'. They expressed a strong desire to master the dementia-related challenges of their residents with dementia but felt both understaffed and unqualified to do so.

> There are volunteer nurses during the daytime, but we are only two nurses over here, hired by the government. There are too many residents. Giving them medicines, taking them to the hospital—there is need for a lot of things over here. There is a need for a counsellor. There is a need for a physiotherapist for people with joint problems. There is a need for recreational activities because there are many residents who don't have their families around, so we need to bring happiness into their lives even for a while. There is a need for a dietician over here because even patients with dementia may have diabetes
>
> (Nurse, Government OAH).

The HCPs referred to the need for a sufficient number of HCPs to provide individual dementia-specific care, that is more nurses to provide everyday nursing care, physiotherapies to support and maintain their mobility and social activities that are based on the functional abilities of each resident with dementia, and dieticians as residents with dementia may also have comorbidities.

4 | DISCUSSION

Conducting research in regions of the world that is underrepresented in the gerontological nursing literature—from settings not typically addressed in that literature, is of great importance. Our findings illuminate a highly significant subject for the international community of older people nursing that is too often neglected in health policies; critical challenges in current dementia care—in this case as perceived by HCPs in Nepalese OAHs. This study provides increased knowledge for policymakers within the healthcare sector and the educational sector, and for HCP organisations and leaders with responsibility for OAH management in Nepal. We will, therefore, address these critical challenges from a broader perspective, drawing upon previous research, recommendations of Alzheimer's Disease International, and the WHO's plans and guidelines for all member states—on how to develop quality care for citizen with dementia.

The study findings reveal three major challenges in current Nepalese OAH dementia care. First, the HCPs participating in the study described themselves as professional caregivers with limited specific educational training in dementia-specific care and, therefore, as having sparse knowledge of dementia syndrome and how to meet the individual needs of those affected by it. They described inappropriate care given in everyday settings by HCPs who were not professionally trained to cope with the residents' cognitive impairment and BPSD—thus undermining adequate care. There is something critical in this message; it concerns the HCPs' experience of not being able to provide proper dementia care due to limited knowledge of dementia and dementia-specific care for residents living with this condition. Our findings in the OAH setting are coherent with previous research exploring dementia care management in hospitals in Kathmandu, which indicates that limited knowledge made nurses feel insufficiently prepared and less confident about delivering appropriate dementia care services (Pathak, 2015). Our findings also resonate with those of Pathak and Gaire (2020), who found a lack of knowledge, awareness and competency among registered nurses in Nepalese nursing home settings, without any updates on newly established guidelines or training related to dementia diagnosis. Our findings also support *Dementia assessment and management protocol for doctors in Nepal*, by Jha and Sapkota (2013), which discusses the need for improved diagnostic examination practice and post-diagnostic care and management of BPSD. We also explored the need for dementia assessment, diagnosis and treatment strategies as a part of residential care in the OAHs with large numbers of older residents. As an example, in our study we found that HCPs in a government OAH suspected residents to have cognitive symptoms of dementia but had no diagnosis, treatment and care facilities related to dementia.

As we understand it, the research now indicates a need for HCP educational planning in Nepal that emphasises theoretical education and practical training in dementia-specific care. In line with Pathak and Gaire (2020), we argue that Nepalese nurses need sufficient training to be able to provide quality dementia care to their residents. Concerned about conducting a care practice based largely upon personal experience, individual skills and preferences, the HCPs in our study explicitly stated that they had a need for education and training in dementia-specific care, to enable them to provide care for their residents according to professional standards. We recommend annual mandatory dementia-specific care training for nurses and allied HCPs to be implemented in OAHs, as we believe that such obligatory training is an important strategy to improve the quality of current dementia care practice. Prakash et al. (2018) have previously addressed the need for a strong policy and legislation for achieving better quality in education and nursing services in Nepal. Based on our findings, we believe this is a central theme for policymakers to act upon, as it will increase HCPs' understanding of dementia syndrome and how to promote professional dementia-specific care.

The second critical challenge identified in this study indicates that the HCPs' insufficient competence made it difficult for them to cope with residents' cognitive disturbances and BPSD—a finding that seems closely related to their limited dementia-specific care education. In long-term care facilities like OAHs, managing behavioural problems in dementia and providing individualised care, including emotional and psychosocial support, are vital for the welfare of these residents (Cadieux et al., 2013). Research shows that aggressive behaviour by residents with dementia often occurs in settings where HCPs are providing personal care (Baker et al., 2006; Schreiner, 2001; Sloane et al., 2004,2007). As these residents may have difficulties in verbally communicating their needs, they often communicate through need-driven, dementia-compromised behaviour (NDB), such as disruptiveness, agitation and aggression. Knowledge of this is a prerequisite for staff to understand that such behaviour is an expression of the residents' physical, psychological,

emotional and social needs (Kovach et al., 2005; Scott et al., 2011). Staff education strengthens the use of professional skills in identifying and managing trigger factors for aggressive behaviours and facilitates reflection on the ethical implication of their care (Enmarker et al., 2011). Moreover, educating staff in social interaction is vital, as inadequate knowledge of this type has been strongly associated with aggressive behaviour among residents with dementia (Chen et al., 2000; Enmarker et al., 2011). Research on person-centered care (PCC) has shown that PCC interventions have significantly decreased challenging behaviour among residents with dementia and reduced psychotropic medication use among residents in long-term care (Li & Porock, 2014). Studies also show that PCC has reduced the use of physical and chemical restraint on residents with dementia (Chenoweth et al., 2009). PCC is based on the belief that personhood can be maintained despite the cognitive impairment of people with dementia and was first described by Kitwood (1997), a pioneer in humanistic dementia care (Stein-Parbury et al., 2012). In our study, HCPs underlined the importance of fulfilling the psychosocial needs of their long-term residents with dementia. However, due to sparse resources and a workforce with limited training, the quality of person-centred dementia-specific care practice was negatively affected. Few HCPs were trained in how to organise social and recreational activities and manage behavioural symptoms. When delivering services like music therapy and organising religious and spiritual activities, most HCPs drew on their individual experiences from everyday practice. They expressed a desire to receive training and build competence on how to professionally cope with BPSD and how to implement activities and therapies.

The WHO (2016a) emphasises that underinvestment in education and training programmes for HCPs, the mismatch between the population's needs and the healthcare educational strategies that are adopted are concerns that are important to address. We argue that well-educated HCPs are a prerequisite for succeeding in knowledge translation (KT), a paradigm that addresses the need for closing the *know-do gap* (WHO, 2012). KT is defined as 'the synthesis, exchange and application of knowledge by relevant stakeholders to accelerate the benefits of global and local innovation in strengthening health systems and improving people's health' (Pablos-Mendez & Shademani, 2006; WHO, 2012). In our opinion, KT is imperative in OAH dementia care practice to ensure that the relevant stakeholders within healthcare management are building and establishing a sound KT culture. We believe that HCPs who are well-educated in dementia syndrome and dementia care, and who are part of a KT culture, and being given opportunities to stay up to date on research, can, as stakeholders, succeed in closing the 'know-do' gap within this setting. A guiding framework for the application of KT in ageing and health has been developed by the WHO (2012) and can be used for this purpose. We also believe that deploying well-educated HCPs and establishing a culture for KT in dementia care practice also can serve as a turning point for the nursing assistant in OAHs. As underscored by the WHO (2018a), the unskilled workforce of community health workers (CHWs), including nursing assistants, should be considered in relation to other HCPs in order to integrate CHWs training programmes into the community healthcare system. Such competence can qualify CHWs to play a more active role in dementia-specific care, such as safely and professionally assisting these residents during transport to hospital for specialist consultations.

The need to effectively match the supply of professional health workers with the population's needs (WHO, 2016a) is actualised in the third critical challenge of current dementia care found in our study, namely, the HCPs' experience of a poor ratio between HCPs/MDs and patients. As previously described by Khanal and Gautam (2011), insufficient staff deployment affects the management of health problems among OAH residents in Kathmandu. In their study concerning the mental health workforce gap in LMIC, Bruckner et al. (2011) found that there were only 0.13 psychiatrists, 0.27 nurses and 0.19 psychosocial providers per 100,000 population in Nepal, while the targeted numbers required were 288, 2928 and 2549, respectively. The WHO (2016b) stresses that the mismatch between the population's needs for healthcare services and the supply of doctors and nurses in LMIC is a problem that has to be addressed—in this present case, to secure proper diagnostic examination, treatment and dementia-specific care for this patient group. We, therefore, suggest that educating and deploying sufficient MDs and HCPs in OAHs should be emphasised in order to achieve this goal. To address this, we encourage the Nepalese government to allocate health budgets towards dementia care and invest in recruitment and training of nurses, doctors and nursing assistants / CHWs for increasing their competencies. It is also essential to use various incentives and aid programmes for HCPs to encourage and motivate HCPs like nurses, physiotherapists, doctors and nursing assistants / CHWs to choose dementia care as their professional field of practice. Financial incentives like improving salaries and benefits are essential to motivate young professionals to academic careers in specialties like geriatrics, gerontology and dementia. In addition, we also recommend governmental support and encouragement for older and newly established OAHs for funding purpose. We, therefore, suggest that educating and deploying sufficient MDs and HCPs in OAHs should be emphasised in order to achieve this goal. The WHO (2017a) specifically highlights the importance of aligning healthcare systems to the older population's needs, including by developing sustainable and equitable systems for providing residential long-term care. As formulated in the *Global action plan on the public health response to dementia: 2017–2025* (WHO, 2017b), the number one global target is that 75% of countries will develop or update national policies, strategies, plans or frameworks for dementia during this period. All member states are therefore called upon to develop and apply national dementia policies, legislation, strategies and plans (Alzheimer's Disease International, 2019; WHO, 2017b,2018b). Several countries have now developed and implemented national dementia plans, which are vital for improving quality as this relates to diagnosis, treatment and care. Nepalese mental health policy has progressed since 2018, but no national dementia plan has yet been implemented (Alzheimer's Disease International, 2019).

A comprehensive and multi-sectoral approach is highly recommended in the development and coordination of policies, legislation, plans, frameworks and integrated programmes of care. This will help enable each country to recognise and address the complex needs of its citizens with dementia (WHO, 2017b). The HCPs who participated in this present study have provided their considered perspectives of the critical challenges that are reducing options for quality dementia care in OAHs. In line with Wang et al. (2018), we support the perspective that learning from HCPs' experiences is crucial when developing policies and implementing educational interventions to improve healthcare services for people with dementia. We strongly encourage the process of preparing, developing and implementing a coordinated national dementia plan in Nepal that also includes strategies for dementia-specific care education for HCPs, CHWs and how to facilitate a KT culture in healthcare for people living with dementia—as we believe that this is an important strategy for overcoming the critical challenges of current dementia care practice.

4.1 | Limitations

The data obtained in this study originated from a participant group not previously consulted concerning critical challenges in current OAH dementia care. However, the study has several limitations. Only eleven HCPs participated, and with seven of them only one interview was conducted. Recruiting a larger sample and conducting two 60- to 90-min interviews with all participants would most likely have added further breadth and depth to the empirical data. However, as we experienced in our research, even with small samples qualitative studies can generate a new in-depth understanding of phenomena we have limited knowledge of (Brinkmann, 2012). In four of the OAHs, residents had been diagnosed with dementia by specialists. In the government OAH, however, there were many residents with what HCPs believed were dementia-related symptoms although these had no dementia diagnosis. We, therefore, address the lack of diagnosis as a study limitation, as we cannot exclude the possibility that some of these residents could have been affected by other diseases than dementia.

5 | CONCLUSIONS

Understanding critical challenges hindering quality care for persons with dementia and how to overcome them is a subject of great importance for the international community of older people nursing. Regions underrepresented in the gerontological nursing literature are in need of research-based knowledge that can help improve their educational practice and healthcare services. Investigating the perceptions of Nepalese HCPs, this study found that limited educational training in dementia-specific care, insufficient HCP competence undermined adequate coping with residents' cognitive disturbances and BPDS and a poor ratio between HCPs/MDs and patients were all critical obstacles to quality dementia care in Nepalese OAHs. To overcome these challenges, a coordinated national plan for dementia care and plan for HCP education in dementia-specific care, including educational plan for CHWs, can be an important strategy facilitating a growing KT culture in healthcare for people living with dementia. Improved coherence can be progressively developed between, on the one hand, national strategies for education, health, finance, labour and employment, and, on the other, a health workforce of HCPs and MDs whose numbers and competence are adequate to ensure diagnostic examination, treatment and dementia-specific care.

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CONFLICT OF INTEREST

The authors declare no conflicts of interest.

AUTHORS CONTRIBUTIONS

Study design: SS and OT; data collection: SS; data analysis: SS and OT; manuscript preparation and final approval of the version to be published: SS and OT.

DATA AVAILABILITY STATEMENT

Due to participant confidentiality, the collected data material will not be shared.

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