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Background:

Geriatric hearth service facilities for the elderly were established in the 1980s as intermediate facilities for rehabilitation. At the time of its establishment, it was not envisaged that it would support for medical treatment and living of clients who increased medical needs. Even now, medical facilities are limited to minimal medical facilities, and the number of doctors and nurses, who are medical workers, is limited. A disease that clients are likely to contract is nursing and healthcare-associated pneumonia (henceforth, NHCAP). NHCAP refers to pneumonia that occurs in nursing homes, etc., and is mostly considered aspiration pneumonia (Japanese Respiratory Society, 2018). The Guidelines for the Treatment of Adult Pneumonia 2017 clearly stated treatment and care options that consider the individual's wishes and quality of life when the risk of recurrent aspiration pneumonia or end-stage disease or senility is recognized. The 2012 revision of the long-term care reimbursement set up an additional fee for facility care for certain diseases, which allows the use of antimicrobial agents in cases of pneumonia. Thus, when a client contracted NHCAP, a geriatric healthcare facility became one of the places for treatment.

Nursing research on NHCAP in geriatric health service facility clarified the decision process of morbidity detection and recuperation place by Koguma et al. (2021). Matsumoto (2023) investigated changes in the Functional Independence Measure (hereafter, FIM) and recuperation support for NHCAP clients. As a result, 5 out of 6 clients maintained or improved their FIM values. And it was confirmed that the nursing staff worked so that the care worker could continue to support the clients with NHCAP.

Kato et al. (2009) reported that ADL decline occurred in 30% of the elderly who were hospitalized at a medical institution. Based on the report by Kato et al. (2009), there is a possibility that the recuperative life support provided at the geriatric health service facility affects the ADL of the clients, and that the recuperative life support at the geriatric health service facility Nursing strategies were speculated.

However, the specific aspect of NHCAP recuperative life support by nursing under the geriatric health care system for the client has not been clarified.

Therefore, we considered it necessary to clarify the specific aspects of the change from daily life support to recuperating life support under a system with limited medical facilities and personnel of medical personnel.

Objective:

To identify nursing strategies to continue to support medical care and living to clients with NHCAP in geriatric healthcare facilities system.

Specifically, we will descriptively clarify the recuperative life support provided in the geriatric

health service system.

Methods:

Interview data were analyzed using methods that invoked qualitative descriptive research methods. Categories were classified by content similarity and difference. Strategies were extracted from the sorted categories.

Results and discussion:

Seven nurses were study participants. The results of the analysis showed that the categories were: the time of NHCAP prevention and detection of signs of NHCAP (henceforth, Phase I), the time of NHCAP diagnosis and provision of antimicrobials and preparation for resumption of pre-illness life (henceforth, Phase II), the time of NHCAP when the client could not resume pre-illness life and NHCAP was the period of transition to senility and end-of-life care, where the clients repeatedly suffers from NHCAP (henceforth, Phase III), and the usual support foundation of geriatric health service facility, which provides indirect support during NHCAP for what is normally done regardless of the client's NHCAP (henceforth, Support foundation). Some excerpts from the categories and their contents are given below.

Phase I: There were eight categories, including [In-depth measures on eating to keep the client the energy that it is all could do], [Detection of signs of illness and rapid information sharing between professions]. Among these, the nursing staff's report to the doctor of "pneumonia-like" in [Detection of signs of illness and prompt information sharing between professions] was considered to have been based on the staffing structure of the geriatric health service facility, and the limited doctor's staff was considered to have responded by partially amplifying their own medical assistance. Nurse observed clients together with care workers. Nurses and care workers are characterized by the multilayered nature of the support for medical treatment and living that caregivers and nurses simultaneously provide in the same place from their respective roles.

Phase II: There were five categories. [NHCAP severity of illness and judgment of the place of treatment based on the medical resources of the geriatric health service facility] It was found that the implementation of treatment using antimicrobials as a medical resource is also recognized as an additional resource, with a view to maintaining the management of the geriatric health service facility.

In the category [Preparation for resumption of pre-illness life, starting with food intake], the assessment of swallowing function and eating patterns of clients at high risk of aspiration was requested from speech therapist, making use of their expertise; when speech therapist was not

available, the nursing staff temporarily took over as part of the support for medical treatment and life, and when speech therapist was working, the reassessment of swallowing function was requested again. The strategies are utilizing expertise through the division of labor.
Phase Ⅲ: There were four categories. Consisted of [sharing with family members the prospect that repeated NHCAP is a transition to end-of-life care], [end-of-life care in the patient's own life], [dealing with fluctuations in feelings regarding choice of place for end-of-life care] and [recognition of acceptance of end-of-life care by care workers]. During the transition period to end-of-life care after repeated NHCAP, NHCAP was regarded as a process of physical changes in old age, and nurses prepared for a natural end-of-life care in cooperation with other professions and family members.
Support foundation: Consists of 9 categories including [reconsideration of medical care followed the way of life]. Nurse was felling impatient by the limitations of medical resources. And they aimed to keep the client's "the energy that it is all could do" of a client.
They meant that recuperative life support at a geriatric health service facility is not solely focused on medical care but is also oriented towards living.

Conclusion:
Analysis of the work of the nursing profession under geriatric health service facility-system with limited medical resources. The specifics of medical care that is in accompaniment with their life and collaboration with other professions to make use of their expertise were extracted. The strategies of the nursing profession identified in this study can be utilized as a foothold for building support for medical treatment and living in geriatric health service facility. In addition, from the results of this study, it is possible to start considering what diseases and conditions can be accepted in geriatric health service facility and what systems need to be prepared to accept them.