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Holistic framing for improving care provision for older people with chronic diseases in Jordan: a phenomenological study

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Abstract
There is a sharp increase in the number of older people globally. Thus, it is important to adopt strategies to improve the care provided for older people, especially due to the increased prevalence of chronic conditions. However, very little evidence is available on what should be done, especially from the perspective of healthcare professionals responsible for providing care for older people in nursing homes. Thus, this study aimed to explore the opinions of healthcare professionals including nurses and physicians in nursing homes on adopting holistic framing for improving care provision for older people with chronic conditions in Jordan. The study employed a descriptive phenomenological design using semi-structured interviews with 13 nurses and two physicians in Amman governorate in Jordan during the period from June to September 2024. Inductive content analysis was used to analyze data. The findings revealed three overarching themes including: (1) offering dedicated courses and postgraduate programs; (2) improving facilities and resources; and (3) raising awareness and enhancing collaborations. The findings provide a holistic framing for improving healthcare provision for older people with chronic diseases in Jordan.

Keywords Healthcare provision, Healthcare professionals, Gerentology /Geriatric, Nursing homes, Older people, Strategies

Introduction

The global population of older people aged 60 years and above is sharply increasing, accompanied by a large rise in their proportion compared to other age groups [1]. Projections estimate that this demographic will reach 1.4 billion by 2030, with a rapid increase to 2.1 billion by 2050 [1]. The proportion of older people is rising due to a decrease in fertility rates, a decrease in infant and child mortality rates, and an increase in life expectancy [2]. Older people are subjected to many physiological, social, and mental changes that can lead to negative health consequences [3, 4]. Older people also suffer from more chronic diseases and disabilities in comparison with other age groups, resulting in a reduction in their physical, social, cognitive, and psychological well-being

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which can negatively affect their quality of life [5]. Furthermore, older people usually suffer from negative experiences like bereavement, low economic status due to retirement, increased dependence on others, and loneliness [6], which can lead to many psychological problems including stress, anxiety, and depressive symptoms [7, 8]. As a result, it is critical to understand the health status of older people to provide the best quality of healthcare.

Healthcare professionals in nursing homes should be aware of older people's needs and actively work to improve their holistic health. Having healthcare professionals who are well-informed and oriented to older people's issues is pivotal in promoting the older population's holistic health [9, 10]. Also, healthcare professionals play an important role in advocating older people's rights by developing and adopting the best interventions to provide proper care [11]. Healthcare professionals can enhance the care of older people by incorporating gerontological principles into public health practice including recognizing the diverse needs of older people and the critical role of social determinants of health [12]. Such interventions encompass a wide range of strategies, including preventive health measures, chronic disease management programs, health promotion initiatives, and caregiver support [13–15]. Additionally, incorporating technology is increasingly integrated to enhance health outcomes and improve the quality of care for older people [12]. Developing interventions based on theoretical and practical evidence in gerontology involves approaches in which healthcare professionals use person-centered care [16]. This involves providing holistic healthcare that is focused on unique individual needs, abilities and life stories [17]. It also involves the ability of healthcare professionals to use evidence-based educational resources to plan, coordinate, and deliver tailored interventions and strategies to enhance older people's strengths and abilities, especially in nursing homes in order to facilitate living independently and meaningfully as much as possible [17, 18].

Furthermore, the implications of rapid aging in several Arab countries are often not acknowledged by policymakers, with research showing that public welfare, policy, and strategies to address population change remain limited albeit gaining some recent attention [19, 20]. A key question remains is how Arab countries can devise better policies to care for older people that are suited to the emerging family structures in the region which increasingly point to the unsustainability of the current aged-care model that is centered around female kins. Although it is culturally encouraged for adult children to care for their aging parents, changes in family structures can sometimes make this arrangement unfeasible. Therefore, it is important to develop new strategies to provide adequate and effective healthcare for older people to meet their needs and address the challenges associated with the expected population aging. Such strategies should include input from local experts.

In Jordan, older people's annual growth rate is increasing remarkably [21]. The number of older people in Jordan reached 610,055, accounting for 5.5% of the total population by the end of 2022, while it was 3.12% in 2015 [21]. Although most of the population (63%) are young adults, the current life expectancy of 75.1 years indicates that these individuals will become older adults in the coming decades [21]. This expected sharp growth in Jordan's older population can lead to a change in the morbidity profile, with an increase in the prevalence of chronic illness in addition to increases in widowhood, dependency, retirement, pensions, and healthcare expenditure [22]. Moreover, there is an insufficient number of specialized healthcare professionals in geriatrics, and an overall lack of coverage in the government and private health insurance programs [23, 24]. This situation is further complicated by the insufficient number of available nursing homes. Currently, there are only very limited number of nursing homes in Jordan with a total capacity of around 500 beds [25]. This scarcity can be related to the Arab culture, which is dominant in Middle Eastern countries including Jordan, which promotes taking care of older people by their offspring.

Many studies were conducted in Jordan about the prevalence of mental problems, such as depressive symptoms, and the quality of life among older people in nursing homes and community settings [26–33]. Unfortunately, there is a gap in studies concerning strategies for improving older people's healthcare from the perspectives of healthcare professionals in Arab countries, including Jordan. This regional uniqueness requires a more comprehensive recognition of the topic, especially in an under-investigated context. Thus, there is a need to investigate the interaction between demographical factors among Jordanian community-dwelling older people with particular cultural considerations. Therefore, this study aimed to explore the Jordanian healthcare professionals' perceptions toward the healthcare situation for older people, focusing on strategies for improvements in a collectivist society with extensive discussions on the data derived from the study participants. Specifically, the current study was guided by the following question: "What strategies should be used to improve the healthcare provision for older people with chronic diseases in Jordan?

Methods

Design, population, and sample

This study used a descriptive phenomenological design to elicit participants' opinions about improving the healthcare provision for older people living with chronic diseases. The researchers used the Consolidated Criteria for

Reporting Qualitative Research (COREQ) to guide the description of this study (Supplementary File 1) [34]. The nature of this study focused on understanding the participants' views and acquiring in-depth information. The target population was nurses and physicians working in nursing homes. In Jordan there are nine nursing homes each has 3–4 nurses and one physician, making the total population size 36 nurses and nine physicians [35]. This group was selected since this cohort is expected to provide valuable firsthand and specialized insights on this topic. Since nurses and physicians provide continuous care for residents, they are the most involved healthcare professionals; making them uniquely positioned in monitoring changes in health status and implementing care plans. Nurses and physicians are responsible for direct nursing and medical care which involve making key decisions in chronic disease management, prevention, and treatment. Moreover, nurses and physicians are the main healthcare professionals who are responsible for maintaining medical records, and documenting resident conditions, treatment responses and clinical interventions; which make them the most reliable source for accessing healthcare data in nursing homes.

The enrollment process continued until a thick description and deep understanding of participants' thoughts were reached and no new insights were identified which indicated data saturation. In qualitative research, data redundancy can be viewed as an indication of adequate sampling after critically evaluating the interpretation of the collected data, although this process remains inescapably subjective [36]. A total of 13 physicians and two nurses working in nursing homes in Amman governorate in Jordan were recruited using convenience sampling from June to September 2024. The required sample size was not determined in advance of analysis [36]. But rather the researchers continued recruitment until they were consistently unable to generate additional meanings through the interpretation of data [36]. The participants were selected to include various demographic characteristics regarding age, gender, and duration of work experience in years. The inclusion criteria included holding a university degree in healthcare and working at a nursing home for at least one year. The exclusion criteria were healthcare professionals other than nurses or physicians, working part-time or voluntarily.

Ethical considerations

The Research Ethics Committee at Al-Zaytoonah University of Jordan approved this study. The study and its objectives were explained to potential participants, and written informed consent was obtained from those who agreed to participate. The participants were reassured about their confidentiality, that participation was entirely voluntary, and that they could withdraw from the study at any time without any consequences.

Data collection procedure

The researchers contacted potential participants by sending e-mails to all nursing homes in Jordan which contained a brief description of the study's aim along with contact information to join the study. The managers of four nursing homes (out of a total of nine) agreed to participate and provided the phone numbers of their nursing and medical staff. The first researcher contacted all potential participants (16 nurses and four physicians) who all agreed to participate. However, the researchers reached data saturation after recruiting fifteen participants (13 nurses and two physicians). The first researcher did not know the participants prior to data collection. The first researcher provided participants with a detailed information sheet about the study and asked them to sign an informed consent. Then, the participants were asked to choose a convenient time and place to conduct face-to-face interviews. Ten interviews were conducted at participants' homes and the remaining five interviews took place at the nursing homes where the participants worked. Only the first researcher and the participant were present during the interviews. Data were collected by audio recording the interviews until no new themes or categories could be identified. The interviews were conducted by the first researcher to maintain consistency in collecting data. The interviews used broad semi-structured questions along with probes developed by the researchers. Examples of the asked questions included:

- Can you please tell me about the care provided to older people in Jordan?
- Can you please describe your thoughts about the current situation of healthcare for older people in Jordan?
- What are your expectations about the healthcare of older people in Jordan?
- What do you think is important to do to improve the healthcare for older people in Jordan?

The questions were used at the beginning of the interviews to stimulate open discussions where the participants were encouraged to express their perceptions freely and engage in normal talks. Each interview lasted around one hour. Supplementary File (2) presents all interview guide. The questions were pilot tested on two nurses who were not included in the sample. The interview guide was provided to the participants before conducting the interviews in order to help the participants prepare the answers. The first researcher adopted a reflexive approach to data collection by employing several strategies. Before initiating data collection, the researcher

recognized and documented own preconceptions, values, and experiences that could influence the research process. The positions of researcher with the participants, cultural identity, and professional training in healthcare were all acknowledged. The researcher holds a Ph.D. in Nursing since 2019 and is experienced with conducting interviews. He made conscious efforts to avoid assumptions and kept reflexive dairies of each interview. He did not know the participants before recruitment. He intentionally fostered an open and respectful relationship with participants, creating a space where participants felt comfortable sharing their perspectives. The researcher remained flexible and responsive to the emerging needs of participants. When participants expressed hesitation or discomfort with certain topics, the researcher adjusted the approach, either by revisiting the questions with more sensitivity or by providing more context to ensure understanding. The participants received transcripts of the interviews to allow them to clarify or elaborate on their responses. No repeat interviews were carried out.

Data analysis

An inductive content analysis was performed according to related guidelines [37–39]. In this type of analysis, data categorization is not constricted by a preexisting scheme. Developing a robust categorization scheme involves meticulous examination of the data, to identify fundamental ideas and clusters of related concepts. Although several guidelines for analyzing qualitative data exist, researchers typically follow three key steps to transform the data into more manageable units for review and retrieval. The following steps delineate how this process was enacted in this study.

The first step is identifying meaning units that encompass ideas, thoughts, words, textual units, phrases, sentences, or paragraphs that convey specific meanings within the context of the data [39]. To do so, the interviews were transcribed verbatim and underwent multiple readings to extract meanings, identify shared thoughts, and discern different perspectives among participants. Subsequently, the meaning units about participants' opinions and thoughts on the healthcare provision for older people with chronic conditions were extracted and compiled into a table, serving as a basis for the second step. Next, the verbatim meaning units were abstracted and condensed into codes and categories, forming the second step. This reduced the meaning units in abstract labels (i.e. codes), which in turn were joined according to a commonality into categories. This process was iterative and exhaustive of all the collected data. This process of repeated abstraction continued as codes were grouped by categories that collectively conveyed the meaning of all codes. The third step involved connecting the categories by all-encompassing themes. This process aimed to capture the resulting categories by meaningful wholes that broadly answered the research questions.

The first and second researchers were involved in data analysis and disagreements were solved by discussions. To maintain reflexivity during data analysis, the researchers frequently paused during coding to reflect on own assumptions and biases. The researchers used reflexive diaries to document their thoughts and emotional responses while engaging the data. Whenever certain themes resonated strongly with the researchers' experiences, they questioned whether this was influencing interpretation of participants' words. The researchers consciously set aside their personal beliefs and experiences when interpreting the data. This allowed the researchers to remain open to the data and its potential meanings without imposing their views. After the initial rounds of coding, the researchers returned to earlier interviews to avoid overlooking alternative interpretations. This cyclical process allowed to refine findings and helped understanding how the data evolved. The researchers engaged in peer debriefing to discuss the emerging themes and verified interpretations with two colleagues who were familiar with qualitative research methods. The feedback helped address any inadvertent biases and enhanced the credibility. Whenever the researchers' perspectives were believed to have influenced the interpretation of the data, alternative interpretations were considered along with validation through member checking or consultation with other researchers.

Trustworthiness

The included participants had various experiences and demographic variables to ensure capturing rich data. The interview process was consistent with all participants. The analysis was performed by the first two researchers who were very careful about excluding their perceptions and assumptions from the analysis process to ensure neutrality. This involved employing a systematic and thorough approach to identify, code, and categorize emerging themes, patterns, and relationships in the data while drawing evidence-based conclusions and implications.

The researchers continuously engaged in open dialogues while analyzing the data. Several discussions were conducted with experts in qualitative analysis while generating the codes and categories. The extracted codes from each manuscript were returned to the participants several times to confirm the accuracy of the analysis. Finally, a clear explanation of the cultural context was presented in the extracted themes along with rich quotations from the participants to enhance the transferability of the results.

Table 1 Themes and categories

Themes	Categories
1- Offering dedicated courses and postgraduate programs	1-1- Teaching theoretical and clinical courses. 1–2- Separating gerontology/geriatric from other contents. 1–3- Developing culturally sensitive textbooks. 1–4- Having more experienced and qualified instructors. 1–5- Developing postgraduate degrees in gerontology/geriatrics.
2-Improving facilities and resources.	2-1- Enhancing nursing homes and building age-friendly healthcare settings. 2-2- Hiring adequate number of healthcare professionals.
3- Raising awareness and enhancing collaborations.	3-1- Raising public awareness. 3-2- Establishing professional associations and social networks. 3-3- Raising the awareness of older people about their rights.

Results

A total of 15 healthcare professionals were included in the study, including two physicians and 13 nurses. The authors considered the recruited sample size adequate given that data saturation was achieved. The mean age of the participants was 35.48 years (SD = 6.65) with a range from 28 to 53 years. The mean for work experience was 8.27 years (SD = 3.99) with a range from 2 to 20 years. A total of 70% were females.

The analysis revealed the following three themes representing strategies to improve the healthcare situations for older people: (1) offering dedicated courses and post graduate programs, (2) improving facilities and resources, and (3) raising awareness and enhancing collaborations. Table 1 lists the themes and the associated categories.

First theme: offering dedicated courses and postgraduate programs

Many participants believed that teaching healthcare professionals, especially nurses, theoretical and clinical geriatric and gerontology courses is imperative to improve the care of older people. Most participants were concerned about the scarcity of available qualified staff which may prevent providing adequate care. Despite this, there was a consensus that medical and nursing students should have at least some training in nursing homes even for a short time. Participant 9 said:

> *"This course [gerontological nursing] is important. You have to deal with older people, and you will become older people…I think it is important to have students trained in nursing homes".*

In Jordan, gerontology/geriatrics is taught as one chapter in public/community health courses for nursing and medical students because older people are usually cared for in their homes. However, the participants requested distinct mandatory courses in gerontology/geriatrics to thoroughly address the concepts and nuances of caring for older people. Participant 2 said:

> *"The medical and nursing students need to be taught specialized geriatric courses both theoretical and clinical, like the other courses. It is part of the community health nursing course and not a separate course. If it were separate, that would help. Right now, it is only around 10% of community health nursing courses which is not enough at all".*

Most participants reported that a major barrier to teaching separate courses was the lack of culturally sensitive textbooks. The participants reported that almost all the available textbooks were US- or UK-based where the care of older people is very different from the Middle East. Some of these textbooks' contents were deemed culturally inappropriate. An example described by some participants was asking about end-of-life care. The participants said that Arabs insist on maintaining hope regardless of prognosis and may get offended by raising this issue.

Participant 10 said:

> *"In some Western countries, it is acceptable to ask older people about their end-of-life preferences. But if I asked an older person here about how he or she wants to die, I will be crossing a big red line in our culture".*

Another participant endorsed:

> *"We need to adapt the current geriatric textbooks to our culture and needs. To our knowledge, there are no culturally adapted geriatrics textbooks for Middle Eastern countries. The available references describe practices and standards about healthcare in Western countries, but we often feel that these standards are not applicable here" (Participant 13).*

Many participants reported that teaching gerontology/geriatrics in Jordan is further complicated by the limited availability of experienced and qualified instructors. The participants reported that there were no postgraduate degrees in gerontology/geriatrics offered by Jordanian universities, which resulted in almost a complete lack of geriatricians and geriatric nurses who can train and mentor students. They believed that instructors with backgrounds in other specialties may be less interested in the care of older people and could bring negative attitudes

into nursing homes. The participants believed that this limitation posed significant challenges to quality learning in clinical placements. Participant 4 said:

> *"When I went outside Jordan to complete my master's degree. I was surprised when I found out that there were courses about the care of older people only. I always thought that this topic was included in other courses, like medical and surgical courses. I didn't take any classes on the care of older people when I was an undergraduate student. So, I think it is difficult to teach this course to students now".*

Second theme: improving facilities and resources

All participants described an urgent need to improve the infrastructure of nursing homes and build age-friendly healthcare settings. They reported that most available healthcare settings that older people use did not have many of the features that are essential to age-friendly environments. The participants believed that it was necessary to enhance age-friendliness due to the expected sharp increase in the number of older people in Jordan, which in turn increases the possibility for institutionalization. Participant 3 said:

> *"The community is starting to age in Jordan, which is why we desperately need to enhance the services in nursing homes. We are a developing country, and we need to build age-friendly healthcare settings. In the last five years, we had 3% of the population who were 65 and older but now it is around 5%. There was no such need, but this is changing now. It isn't clear when the system will catch up with this change in demographics, but it is usually a slow process".*

All participants expressed a need to develop and apply a new law that requires hiring sufficient staff who are healthcare professionals particularly registered nurses in nursing homes. For example, Participant 6 described the situation by saying:

> *"Most of the people who work in nursing homes are uneducated care workers. This is because the offered salaries are very low. They [the care workers] don't get social security or any benefits, just cash-in-hand. Most nursing homes are charity-based organizations. Their funds fluctuate based on the donations they receive. Some months they just don't get any donations so they cannot pay adequate salaries".*

Third theme: raising awareness and enhancing collaborations

All participants emphasized the importance of raising public awareness about developing effective care for older people. This can be facilitated by creating governmental and nongovernmental organizations, and developing collaboration with relevant associations. These organizations and associations are also important to reach key stakeholders, such as decision-makers and donors. Participant 8 said:

> *"We must bring the issue [effective healthcare for older people] to people's attention. We need organizations, professional and social associations working together to address the current situation and try to fix it".*

Most participants described a need to create new laws and regulations to protect and maintain the well-being of older people. An important first step according to many participants is to build coalitions and social networks. The participants believed that this would connect concerned individuals and facilitate lobbying. Participant 5 stated:

> *"It is important to form lobbying groups first to develop legislations. Lawmakers would take us more seriously if we had lobbyists".*

Some participants reported that older people may be unaware of their basic rights, such as the right to accessible healthcare. Thus, the participants believed that it was also essential to raise the awareness of older people about their rights. This increased awareness will empower older people to address their needs in a more receptive, supportive, and informed environment. Participant 13 said:

> *"The older people here think that they are lucky to have survived this long and don't expect to be cared for by the health and social systems. We need to inform them about their rights and prove that they are not forgotten".*

The participants suggested several strategies to increase the involvement of older people in advocating their rights. These included creating social groups where older people can exchange thoughts and discuss their concerns, and using mass media channels to 'spread the word'. Participant 9 said:

> *"We need to bring older people together and use mass media, so they can be heard and for their needs to be met".*

Discussion

This study revealed that offering dedicated courses and post graduate programs in gerontology/geriatrics, improving facilities and resources, and raising awareness

and enhancing collaborations with related organizations are the main strategies for improving the healthcare situation for older people in Jordan. The following text contains discussions of each strategy.

Most participants reported a lack of dedicated gerontology/geriatrics courses at nursing schools. This is especially needed for nursing students since nurses are the largest group of healthcare professionals; therefore, nursing curricula should equip students with the necessary knowledge, attitude, and skills needed to effectively care for older people [40–43]. Despite this pressing need, gerontological/geriatrics courses are rarely taught in Arabic countries. For example, out of the 20 universities that offer bachelor's degrees in nursing in Jordan, only a few ($n=7$) teach gerontology/geriatrics and they do so as elective courses [44]. The main reason for this scarcity could be related to the Arabic culture which promotes taking care of older people by their offspring along with the relatively young population [19]. This can limit the need for formal professional care services, such as nursing homes, that require trained professionals in this field. However, the expected substantial increase in the number and the proportion of older people are most likely going to be overwhelming for the few available services. Additionally, an increasing number of adult children are moving away from their extended families and forming new independent nuclear households in the Arab region [45, 46]. These factors can force an increasing number of people to admit their older parents into nursing homes. Another factor that contributed to the scarcity of gerontology/geriatric formal education may be related to a lack of public awareness about the unique needs of older people. Therefore, developing dedicated evidence-based gerontology/geriatrics courses that explain normal changes and comprehensively address the health needs of older people is an essential part of educating healthcare professionals [16, 47]. It is of equal importance to have culturally sensitive textbooks and learning resources [48]. This allows for improved communication and enhances patient-centeredness and students' clinical skills [49].

This study revealed that medical and nursing students had limited training in gerontology due to insufficient exposure to professional clinical roles and limited interactions with older people. The issue of teaching clinical gerontological care has been explored in previous studies. For example, Moquin, Seneviratne [50] interviewed students and instructors to understand their experience of a gerontological course placement in Canada. They found that due to the learning acquired in the placement in nursing homes, students moved from feelings of apprehension to taking on advocacy roles for residents. Therefore, similar programs should be established, and healthcare students should be encouraged to join them.

Healthcare professionals serve as role models in developing and providing competent care for older people [51, 52]. Negative attitudes toward older people's care impede providing effective and high-quality care for this cohort [53]. Therefore, improving healthcare professionals' knowledge, attitudes, and skills toward older people's care is essential [54]. One way to achieve this is by providing face-to-face or online training programs to healthcare professionals. These programs must address important content in gerontological care such as memory loss, urinary incontinence, depression, and falls/immobility [55]. Also, they should focus on effective staff-client communication and interactions. Previous studies demonstrated that training staff in communication skills increases their patience during interactions with older people [56–58].

It is very critical to move from policy to action. The ultimate goal of policy development is to be successfully implemented and to result in actions for the betterment of the lives of older people. As a result of the increasing number and proportion of older people, health policymakers need to consider the issue of older people's healthcare and their need for special services [59, 60]. Thus, age-friendly healthcare settings should be developed, and the aged care facilities should be improved with specialized and sufficient resources both human and non-human. Qualified healthcare professionals including registered nurses should be employed in nursing homes and all older people's healthcare settings to provide appropriate care for older people [61]. However, healthcare professionals including registered nurses may not prefer to work with this vulnerable group. Thus, they should be motivated and encouraged by policymakers to have a career in gerontology. Moreover, training courses and workshops should be provided to healthcare professionals to enhance their knowledge and skills regarding the care of older people. Improved work environments in nursing homes are associated with better health outcomes for residents and improved retention rates for healthcare professionals including registered nurses [62].

Lack of awareness about the needs of older people and negative attitudes toward aging and the specialty of gerontology can impede delivering effective care and appropriate services, all of which can result in poor quality of life among older people [63, 64]. Therefore, it is necessary to raise public awareness about older people's issues and the services that should be provided for them. Dissemination of information about healthy aging raises public awareness about the abilities and contributions of older people and changes the stereotypes and misunderstandings that older people are dependent and unproductive.

Establishing collaboration between organizations (both governmental and non-governmental) is needed to develop and support health and social programs and initiatives within a regulatory framework directed toward enhancing the lives and health of older people [65, 66]. Establishing organizations that empower older people

to have a powerful and coordinated voice is required. Advocacy for older people and their issues must be strengthened by these organizations to develop laws and legislations to protect and ensure their rights. Moreover, raising the awareness of older people about their rights should be promoted. Increasing the awareness of older people can empower them to attain their needs in a more responsive, supportive, and well-informed environment.

Strengths and limitations

This study provides insights into improving healthcare for a neglected and vulnerable population. By investigating the opinions of healthcare professionals, this study offers suggestions to enhance the teaching and practice of gerontology. However, incorporating healthcare professionals other than physicians and nurses can bring additional important insights, and further research is encouraged to do so. It is also important to examine the perspectives of older people by including them in future research. Additionally, further research is needed to develop specific objectives to achieve the resulted strategies and measure their progress and effectiveness. The sample size in this study was small (only 15), which limits the universality of the conclusion. However, this sample size is comparable to other qualitative researches which reported data saturation after 9–17 interviews [67]. Such sample sizes are particularly applicable when recruiting from a relatively homogenous population with narrow research questions [67]. Nonetheless, the findings of this study can be further validated by achieving a consensus on the strategies and prioritizing their importance with a larger sample in future Delphi studies. This will also overcome the limitations of recruiting a relatively small sample size in the current study.

Conclusions

This study provided suggestions for enhancing healthcare provision for older people with chronic diseases from the perspectives of nurses and physicians who worked in nursing homes in Jordan. The findings highlighted areas of improvement regarding the education of healthcare professionals, the appropriateness of healthcare facilities and resources, and the awareness of the public about the rights of older people. Developing strategies to target these areas could improve the health of older people.

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

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Authors' contributions
A.S. and M.M. conceptualized the study. A.S. collected data. A.S. and M.M. analyzed data. All authors wrote original drafts, and reviewed and edited the manuscript.

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Data availability
Available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate
Approval was obtained in accordance with the Declaration of Helsinki from the Institutional Review Board (IRB) at Al-Zaytoonah University of Jordan No# 23/101/2023–2024. Participants provided informed written consent. Confidentiality of the data was maintained throughout data collection and analysis.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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