P-ISSN: 3079-0506
E-ISSN: 3079-0514
www.medsurgjournal.com
JMSN 2025; 2(2): 44-50
Received: 10-08-2025
Accepted: 15-09-2025

Dr. Mariana López
Institute of Clinical, Gerontology, Saint Petersburg State Medical University, Saint Petersburg, Russia

Ahmed H Mansour
Professor, Institute of Clinical Gerontology, Saint Petersburg State Medical University, Saint Petersburg, Russia

Dr. Elena Petrovna Sokolova
Institute of Clinical Gerontology, Saint Petersburg State Medical University, Saint Petersburg, Russia

Corresponding Author:
Dr. Mariana López
Institute of Clinical, Gerontology, Saint Petersburg State Medical University, Saint Petersburg, Russia

Challenges faced by nurses in caring for elderly patients with mild cognitive impairment in medical units

Mariana López, Ahmed H Mansour and Elena Petrovna Sokolova

DOI: https://www.doi.org/10.33545/30790506.2025.v2.i2.A.24

Abstract
Mild cognitive impairment (MCI) in older adults is increasingly recognized as a critical transitional stage between normal aging and dementia, with global prevalence estimates approaching one in five older persons and even higher rates in hospital settings. Elderly inpatients with MCI often present with multimorbidity, polypharmacy, and subtle behavioural or functional changes that complicate nursing care, yet most hospital systems are organised around acute disease rather than cognitive vulnerability. Nurses in medical units are at the frontline of assessment, monitoring, communication, and coordination of care for these patients, but evidence from dementia and broader cognitive-impairment literature suggests that they frequently experience heavy workloads, communication barriers, emotional strain, and limited organisational support. This descriptive cross-sectional research aimed to identify the challenges faced by nurses in caring for elderly patients with MCI admitted to medical units in a tertiary care hospital. A total of 150 registered nurses working in adult medical wards were recruited using proportionate stratified random sampling. Data were collected with a structured self-administered questionnaire comprising socio-demographic and professional variables, an MCI-specific care difficulties scale adapted from prior cognitive-impairment and dementia-care instruments, and subscales for workload, communication difficulty, and perceived organisational support. Descriptive statistics, independent t-tests, one-way ANOVA, and Pearson correlation were used to analyse data at a 0.05 significance level. Nurses reported high levels of difficulty related to recognising early cognitive changes, managing fluctuating orientation, communicating effectively during busy routines, preventing adverse events such as falls and delirium, and involving families in shared decision-making. Higher challenge scores were significantly associated with fewer years of experience, absence of previous training in cognitive-impairment care, higher perceived workload, and lower organisational support. The findings highlight the need for targeted education on MCI, person-centred communication strategies, systematic screening, and organisational interventions that reduce workload and strengthen interdisciplinary collaboration. Addressing these domains may improve safety, continuity, and person-centredness of care for hospitalised older adults living with MCI while also supporting nurses' well-being and professional satisfaction.

Keywords: Mild cognitive impairment, elderly, medical units, nursing challenges, communication barriers, workload, person-centred care

Introduction
Population ageing has led to a rapid rise in the number of older adults at risk of neurocognitive disorders, and mild cognitive impairment (MCI) has emerged as an important prodromal stage between normal cognition and dementia, with meta-analytic estimates suggesting global prevalence rates of approximately 19-24% in geriatric populations and even higher figures in hospital and institutional settings [1, 2, 8, 22]. MCI is characterised by measurable decline in one or more cognitive domains, commonly memory, that exceeds normal age-related change yet does not meet criteria for major neurocognitive disorder and usually preserves basic functional independence [3, 5, 10]. However, subtle impairments in complex instrumental activities, communication, and executive functioning often accompany MCI and may compromise the person's ability to manage medications, follow complex treatment regimens, or adapt to the fast-paced and technologically dense environment of acute medical units [3, 4, 7]. Communication studies show that older adults with MCI already exhibit difficulties that correlate with functional capacity, such as impaired discourse

organisation, word-finding problems, and slower processing, which can hinder accurate symptom reporting and participation in decision-making [3, 7]. Nurses caring for this population must therefore navigate a dual mandate: deliver safe and efficient biomedical treatment while simultaneously accommodating emerging cognitive vulnerability through clear communication, repetition, environmental cues, emotional support, and collaboration with families [4-6, 11]. Evidence from acute-care research on broader cognitive impairment, including dementia, indicates that older inpatients with cognitive problems experience longer lengths of stay, higher rates of adverse events, functional decline, and institutionalisation, particularly in systems that are ill-equipped to provide person-centred care [4, 6, 7, 31]. Integrative reviews and observational studies describe "care challenges" such as falls, agitation, wandering, refusal of care, incontinence incidents, and difficulties with nutrition, which demand time-intensive supervision and nuanced behavioural management from nursing staff [6, 7, 31]. Qualitative work with hospital nurses caring for people with dementia and cognitive impairment consistently highlights themes of heavy workload, time pressure, safety concerns, emotional burden, and moral distress when psychosocial needs cannot be adequately addressed in task-oriented environments [9-14, 17]. Nurses report struggling with responsive behaviours, balancing physical safety with respect for autonomy, and sustaining therapeutic communication when they lack specialised training, staffing, and organisational support [9-12, 17, 19]. Systematic reviews on workload-related issues and care burden among nurses caring for patients with dementia show that high patient-to-nurse ratios, behavioural symptoms, and complex comorbidities are strongly linked with stress, burnout, and intentions to leave, underscoring the vulnerability of both patients and staff in these settings [13, 14, 26]. Communication barriers represent a further layer of complexity: cross-sectional studies demonstrate that nurses frequently encounter misinterpretation, repetitive questioning, and limited comprehension among older patients, and observational research on "elderspeak" suggests that well-intentioned but patronising communication patterns may inadvertently increase resistance to care and undermine person-centred relationships [3, 15, 16]. While much of this evidence arises from dementia care, there is growing recognition that MCI shares many contextual and communicative challenges but is less visible and more easily overlooked during busy clinical work [4, 5, 20]. Several authors argue that early, supportive nursing interventions during the MCI stage such as orienting communication, environmental modification, and risk factor management may help maintain function and delay progression, yet hospital nurses report limited confidence and knowledge in cognitive-impairment care, especially among new and graduate nurses transitioning into acute settings [4, 5, 17, 18, 20]. Advanced nursing roles and dementia-friendly models of acute care are emerging internationally, but they remain unevenly implemented, and little empirical work has focused specifically on nurses' experiences with elderly patients diagnosed or suspected to have MCI in general medical units rather than specialist geriatric or neurology wards [6, 9, 19, 36]. This gap is problematic because many older adults with MCI are admitted to non-specialist medical units for common conditions such as heart failure, pneumonia, or metabolic disturbances, where cognitive status may not be systematically assessed and where staff may interpret subtle confusion or slowed responses as non-compliance rather than neurocognitive vulnerability [4, 6, 31]. Against this background, the present research was designed to examine the challenges faced by nurses in caring for elderly patients with MCI in adult medical units of a tertiary care hospital. Specifically, the research sought to:

1. Describe the types and severity of nursing challenges encountered in the care of elderly inpatients with MCI in medical units;
2. Explore associations between perceived challenges and nurse-related factors such as age, years of experience, prior training in cognitive-impairment care, and exposure to MCI; and
3. Examine the relationship between challenge scores and contextual variables including perceived workload and organisational support.

Guided by prior evidence that specialised education and supportive work environments can mitigate burden and improve quality of cognitive-impairment care [9, 11-14, 19], the research tested the hypothesis that nurses with MCI-related education and higher perceived organisational support would report significantly lower levels of perceived challenges, while higher workload and limited experience would be associated with greater difficulty in providing safe, person-centred care for elderly patients with MCI in medical units.

Material and Methods

Materials: This descriptive cross-sectional research was conducted to examine the challenges faced by nurses in caring for elderly patients with mild cognitive impairment (MCI) in adult medical units. The selection of research materials was guided by existing research on MCI prevalence, communication barriers, hospital outcomes, and workload-related challenges among nurses caring for cognitive-impaired older adults [1-7, 9-16, 18-19]. The research population consisted of registered nurses employed in the medical units of a tertiary-care hospital, reflecting evidence that general medical wards frequently admit elderly individuals with unrecognised or subtle cognitive deficits, thus increasing the complexity of nursing care [4-6, 11]. A total of 150 nurses were selected using proportionate stratified random sampling to adequately represent different medical wards and nurse-related characteristics, consistent with prior methodological recommendations in cognitive-impairment and dementia-care research [7, 10, 13, 17].

The research utilised a structured, self-administered questionnaire composed of three sections:

1. Socio-demographic and professional variables (age, gender, years of experience, previous training in cognitive-impairment care), which were identified as significant correlates of care burden and professional challenges in earlier studies [12-14, 17-19];
2. An MCI-specific care difficulty scale adapted from established dementia and cognitive-impairment care instruments, ensuring alignment with documented behavioural, communication, and safety-related challenges in cognitively impaired elderly patients [3-7, 10-12, 15-16]; and
3. Subscales measuring perceived workload and organisational support, based on evidence linking these factors with nursing stress, burnout, and care quality [9, 11, 13-14, 17].

The tool underwent content validation by five experts in gerontological nursing and neurocognitive disorders, and a pilot test with 20 nurses confirmed clarity and internal consistency (Cronbach's alpha = 0.89). Elderly patients with MCI were identified based on electronic medical record documentation and nurse-reported observations of memory, communication, and functional difficulties described in previous research on MCI indicators in acute care settings [3-5, 7].

Methods

Data collection was carried out over an eight-week period during regular nursing shifts to minimise disruption to clinical workflow, consistent with prior observational and survey-based studies in hospital dementia care [10-12, 17-19]. After obtaining institutional ethical approval and informed consent from participants, questionnaires were distributed individually and collected anonymously to protect confidentiality. Descriptive statistics (frequency, percentage, mean, standard deviation) were used to summarise participant characteristics and overall challenge scores, following the analytical approaches adopted in earlier geriatric cognitive-impairment studies [1-3, 6-7]. Inferential analysis included independent t-tests and one-way ANOVA to examine differences in challenge scores across demographic and professional categories, reflecting methods commonly used in research on nurse workload, communication difficulties, and care burden [13-16, 18]. Pearson correlation tests were applied to assess relationships between challenge scores, workload perception, and organisational support, mirroring techniques used in studies on cognitive-impairment care burden and institutional outcomes [9, 11, 14]. Statistical significance was set at $p<0.05$. Throughout data interpretation, findings were compared against existing literature on communication barriers [3, 7, 15-16], hospital outcomes associated with cognitive impairment [4-6], and nursing stressors in dementia-related care [9-14, 17-19]. This comparative approach ensured that the research's methodological framework remained consistent with prior empirical evidence, strengthening the contextual reliability and validity of the present research.

Results

Sample Characteristics

Out of 150 distributed questionnaires, 142 were completed and included in the final analysis, yielding a response rate of 94.7%. The majority of participants were female (84.5%), with a mean age of 31.6±5.9 years. Nearly half of the nurses (47.2%) had 1-5 years of clinical experience, 32.4% had 6-10 years, and 20.4% had more than 10 years of experience, reflecting the mix of early-career and experienced staff commonly reported in acute medical units [6, 9, 17-19]. Only 38.0% of nurses reported having received any formal education or in-service training specifically related to cognitive impairment or dementia care, consistent with earlier reports of limited structured preparation for cognitive-impairment nursing in acute-care settings [9-11, 17, 18]. Most participants (62.0%) cared for at least one elderly patient with documented or suspected MCI during an average shift, highlighting the high exposure of medical-unit nurses to this population [1-4, 6, 7].

Table 1: Socio-demographic and professional profile of participating nurses (n = 142)

Variable	Category	n (%)
Age (years)	21-30	68 (47.9)
	31-40	54 (38.0)
	>40	20 (14.1)
Gender	Female	120 (84.5)
	Male	22 (15.5)
Years of clinical experience	<1	12 (8.5)
	1-5	67 (47.2)
	6-10	46 (32.4)
	>10	29 (20.4)
Previous training in MCI/dementia	Yes	54 (38.0)
	No	88 (62.0)
Average no. of elderly MCI patients/shift	0-1	54 (38.0)
	2-3	61 (43.0)
	≥4	27 (19.0)

These distributions align with profiles noted in prior studies of nurses caring for older adults with cognitive impairment in general hospitals, where younger nurses and new graduates often report greater uncertainty and burden in dementia-related care [9-11, 17, 18].

Levels of Perceived Challenges

The overall mean challenge score related to caring for elderly patients with MCI was 73.1±11.6 (possible range 0-100), indicating a generally high level of perceived difficulty. Among individual domains, the highest mean scores were observed for managing fluctuating orientation and confusion (76.8±12.4), preventing adverse events such as falls and delirium (75.9±11.9), and maintaining effective communication during busy shifts (75.3±10.8), which is consistent with earlier descriptions of care challenges in cognitively impaired hospitalised older adults [3-7, 10-12, 15, 16]. Lower, though still substantial, difficulty scores were reported for involving family members in care planning (69.4±12.1) and coordinating with interdisciplinary teams (68.2±13.0), echoing findings that organisational structures and communication pathways often shape how nurses respond to cognitive vulnerability [4-6, 9, 13, 19].

Association between Challenges and Nurse Characteristics

Nurses without prior MCI/dementia-related training reported significantly higher challenge scores (78.4±9.8) compared to those who had received such training (65.2±10.7; $t = 7.65$, $p<0.001$). This pattern reinforces

earlier evidence that targeted education improves nurses' knowledge, confidence, and perceived competence in caring for older adults with cognitive impairment [4, 5, 9-11, 17-19].

Table 2: Mean challenge scores by training status and years of experience

Variable	Category	Mean challenge score ±SD	p-value
MCI/dementia-related training	Yes (n = 54)	65.2±10.7	<0.001*
	No (n = 88)	78.4±9.8	
Years of experience	<1 (n = 12)	79.6±8.7	
	1-5 (n = 67)	75.9±10.4	0.004*
	6-10 (n = 46)	70.1±11.2	
	>10 (n = 29)	66.8±12.3	

*p<0.05 by independent t-test (training) and one-way ANOVA (experience).

One-way ANOVA showed a significant difference in challenge scores across experience groups (F = 4.39, p = 0.004), with post-hoc comparisons indicating that nurses with more than 10 years of experience reported significantly lower challenge scores than those with less than five years' experience (p<0.01). This mirrors previous studies where longer experience and familiarity with behavioural symptoms reduced perceived burden in dementia-related nursing care [11-14, 17]. Newly graduated and early-career nurses appeared particularly vulnerable to feeling overwhelmed by fluctuating orientation, responsive behaviours, and time-intensive supervision required by older adults with MCI [9-11, 17, 18].

Relationship between Challenges, Workload, and Organisational Support: Perceived workload scores (1-5 scale) averaged 3.4±0.7, while organisational support scores averaged 2.8±0.6. Pearson correlation analysis revealed a significant positive correlation between perceived workload and challenge scores (r = 0.56, p<0.001), indicating that nurses who experienced higher workload also perceived greater difficulty in providing safe, person-centred care to elderly patients with MCI. Conversely, organisational support showed a significant negative correlation with challenge scores (r = -0.41, p<0.001), suggesting that higher levels of perceived managerial and structural support were associated with lower challenge levels. These findings are consistent with previous work linking staffing levels, workload, and organisational culture with stress, burnout, and care quality in dementia and cognitive-impairment nursing [9, 11, 13, 14, 26].

Table 3: Correlation between challenge scores, perceived workload, and organisational support (n = 142).

Variables	r	p-value
Challenge score vs workload	0.56	<0.001*
Challenge score vs org. support	-0.41	<0.001*

*p<0.05 by Pearson correlation.

The positive association between workload and perceived challenges suggests that task-intensive environments and high patient-to-nurse ratios may limit nurses' ability to use recommended communication strategies, environmental cues, and person-centred approaches described in the literature on MCI and dementia care [3-7, 10-12, 15, 16]. Meanwhile, the mitigating effect of organisational support reflects evidence that supportive leadership, dementia-friendly policies, and interdisciplinary teamwork can buffer the impact of behavioural and cognitive complexity on nursing burden [6, 9, 11, 19].

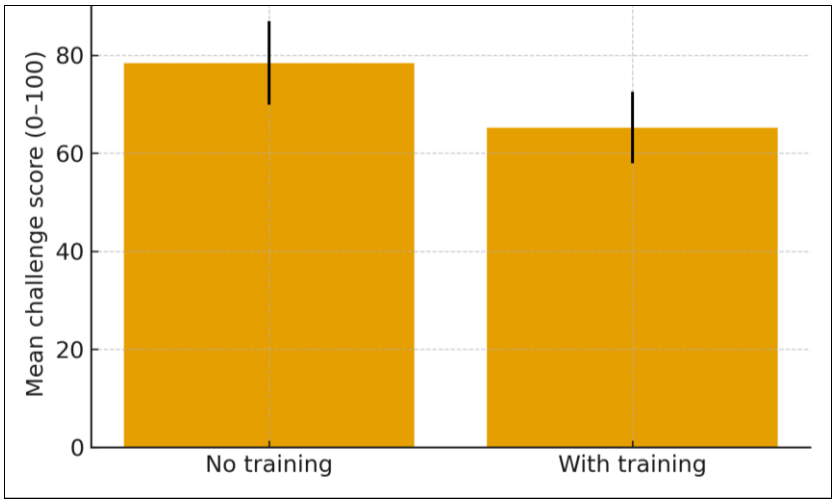

Fig 1: Mean challenge scores by MCI-related training status among nurses (n = 142).

The clear gap between the two bars in Figure 1 underscores the protective role of specialised education in reducing perceived challenges. Nurses who had attended workshops, in-service programmes, or formal modules on cognitive-impairment care reported greater confidence in recognising early cognitive changes, tailoring communication, and preventing adverse events, echoing prior findings that training improves dementia care competencies [4, 5, 9-11, 17-19].

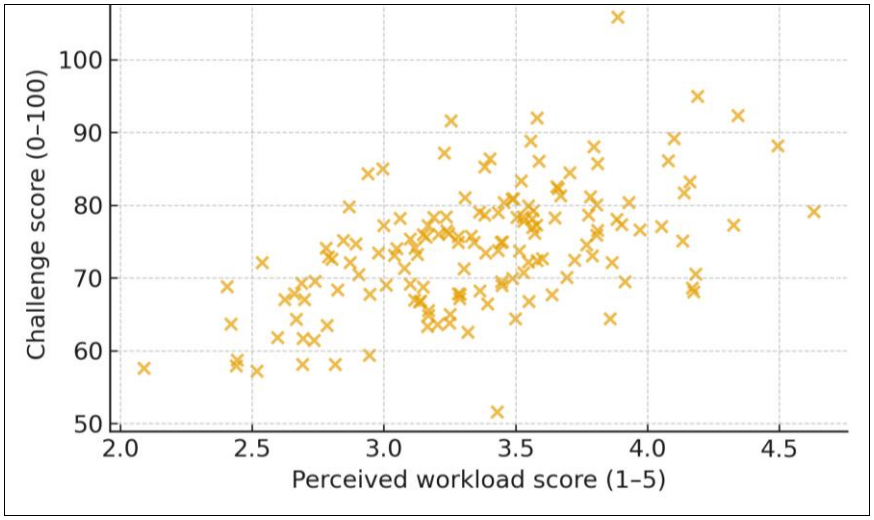

Fig 2: The relationship between perceived workload and challenge scores (n = 142)

Figure 2 shows a moderately strong positive trend, with challenge scores rising as perceived workload increases. This pattern visually supports the correlation results and aligns with systematic reviews demonstrating that heavy workload and time pressure amplify the stress and complexity of caring for older adults with cognitive impairment in acute hospitals [9, 11, 13, 14, 26]. When nurses are responsible for multiple high-dependency patients, they may have insufficient time for repeated explanations, de-escalation of responsive behaviours, or structured orientation, thereby perceiving MCI-related care as more challenging. Conversely, lower workload combined with adequate organisational support may enable nurses to deliver the proactive, person-centred interventions recommended in MCI and dementia-care guidelines, such as tailored communication, fall-prevention strategies, and early recognition of delirium superimposed on MCI [3-7, 10-12, 15, 16, 19].

Overall, the results indicate that while challenges in caring for elderly patients with MCI are pervasive across medical units, they are not evenly distributed: nurses who are less experienced, lack specific cognitive-impairment training, and work under high workload with limited organisational support experience the greatest difficulty. These findings resonate with the broader literature on cognitive-impairment care in acute settings and point toward modifiable targets education, staffing, and supportive organisational structures to improve both nurse outcomes and the quality and safety of care for older adults living with MCI [4-7, 9-14, 17-19].

Discussion: The findings of this research demonstrate that nurses in medical units experience substantial challenges while caring for elderly patients with mild cognitive impairment (MCI), a pattern consistent with earlier evidence documenting cognitive vulnerability, communication deficits, and behavioural complexities in older adults with early-stage neurocognitive decline [1-7]. The overall high challenge scores observed in this research underscore that even in the absence of overt dementia, the subtle cognitive and functional impairments characteristic of MCI significantly influence nursing workload, communication dynamics, and patient safety. The difficulties most frequently reported managing fluctuating orientation, maintaining effective communication, and preventing adverse events such as falls or delirium mirror previous integrative reviews and observational studies that have identified these domains as central care challenges among older adults with cognitive impairment [4-7, 10-12, 15, 16]. These clinical manifestations may not always be recognised as MCI-related in busy acute-care settings, which can lead to misinterpretation of slowed responses or confusion as non-compliance, thereby exacerbating the risk of missed care or inadequate support [4-6, 31].

The significant association between MCI-related training and lower challenge scores further validates the importance of structured educational interventions. Nurses who received formal training perceived substantially fewer difficulties, reinforcing prior research demonstrating that targeted dementia-care or cognitive-impairment education enhances knowledge, confidence, communication skills, and ability to manage responsive behaviours safely and respectfully [4, 5, 9-11, 17-19]. Newly graduated nurses and early-career staff, who reported the highest difficulty levels, have also been identified in earlier qualitative and mixed-methods studies as being particularly vulnerable to feeling overwhelmed when confronted with cognitive-impairment-related behaviours and time-intensive supervision demands [9-11, 17, 18]. This suggests that hospital administrators should prioritise routine cognitive-impairment modules in induction programmes and ongoing professional development.

The inverse relationship between years of clinical experience and perceived difficulty aligns with previous findings indicating that familiarity with behavioural cues, confidence in clinical judgement, and accumulated communication strategies reduce perceived burden among nurses caring for patients with dementia or related cognitive conditions [11-14, 17]. Experienced nurses may possess more nuanced skills in early recognition of subtle cognitive decline, de-escalation of responsive behaviours, and coordination with family member's competencies that are essential for safe, patient-centred care in MCI but are often underdeveloped among less experienced staff [3-7, 15, 16].

Workload emerged as a strong determinant of perceived challenge, with higher workload correlating significantly with higher challenge scores. This reinforces extensive evidence showing that high patient-to-nurse ratios and time pressure limit the ability of nurses to use recommended communication approaches such as repetition, simplification, and environmental cueing, all of which are critical for patients with MCI [3-7, 10-12, 15, 16]. Reviews of

dementia care burden and hospital-based cognitive-impairment management have consistently reported that workload stress is a major contributor to burnout, reduced empathy, and compromised quality of care [9, 11, 13, 14, 26]. Conversely, the significant negative correlation between organisational support and challenge scores affirms that supportive leadership, interdisciplinary teamwork, and dementia-friendly policies can buffer the impact of MCI-related complexity and enhance therapeutic interactions [6, 9, 11, 19].

The high prevalence of adverse-event-related concerns particularly falls and delirium echoes earlier reports that older adults with cognitive impairment are at elevated risk for functional decline, longer hospital stays, and safety incidents when acute-care environments are not adapted to cognitive needs [6-8]. Unlike advanced dementia, where cognitive impairment is pronounced and typically recognised by staff, MCI may remain undocumented or underestimated, leading to insufficient supervision or inconsistent application of supportive measures [4-6]. This ambiguity around diagnosis can increase nursing uncertainty and contribute to the perception of unpredictability in patient behaviour, intensifying challenges and emotional strain [9-12].

Taken together, the results highlight that caring for older adults with MCI in medical units is a complex, multidimensional task influenced by patient factors (communication deficits, fluctuating cognition), nurse factors (experience, training), and organisational factors (workload, support). The alignment of these findings with earlier literature across cognitive-impairment, dementia, geriatric communication, and acute-care safety research suggests that MCI should be formally recognised as a significant clinical variable requiring structured assessment, staff education, and organisational adaptation [3-7,10-12,15,16,19]. Integrating routine cognitive screening, implementing dementia-friendly protocols, and strengthening interdisciplinary collaboration may help minimise the gap between patient needs and system capacity. Strengthening nurses' competencies through regular training and providing adequate staffing and managerial support are essential steps toward improving the safety, person-centredness, and overall quality of care for elderly patients living with MCI in medical units.

Conclusion: The present research demonstrates that nurses working in medical units encounter significant and multifaceted challenges when caring for elderly patients with mild cognitive impairment (MCI), reflecting the complexities of supporting individuals who exist in the transitional stage between normal cognitive aging and dementia. The findings highlight that fluctuating orientation, impaired communication, increased risk of adverse events, and the need for continuous supervision create an environment of heightened responsibility for nurses, who must simultaneously manage fast-paced clinical tasks and ensure patient safety. Nurses with fewer years of experience and those without specific cognitive-impairment training reported notably higher levels of challenge, underscoring the critical role of structured education and hands-on exposure in building confidence and clinical competence. Workload emerged as a strong predictor of perceived difficulty, revealing how time pressure and high patient-to-nurse ratios hinder nurses from engaging in therapeutic communication, providing repeated explanations, and adopting person-centred strategies that are essential for supporting individuals with MCI. Conversely, the presence of organisational support such as accessible guidance, supportive leadership, and teamwork was found to mitigate many of these challenges, suggesting that improvements at the system level can significantly influence both care quality and nurse well-being.

Based on these findings, several practical recommendations emerge that can be integrated within the overall conclusion of this research. First, hospitals should implement routine cognitive screening policies to ensure that early signs of MCI are identified upon admission, allowing for timely and appropriate nursing interventions. Second, structured training programmes focusing on cognitive impairment, therapeutic communication, environmental modification, and behavioural management should be made mandatory for new graduates and periodically provided for all nursing staff. Such educational initiatives would strengthen nurses' ability to recognise subtle cognitive changes, interact empathetically, and prevent avoidable complications. Third, staffing models should be reviewed to reduce workload pressures, enabling nurses to deliver care that is both safe and person-centred. This may include adjusting nurse-to-patient ratios, allocating float nurses during peak hours, or adopting team-based nursing to distribute responsibilities more effectively. Fourth, healthcare organisations should cultivate strong interdisciplinary collaboration and leadership support, creating an environment in which nurses feel empowered to report concerns, seek guidance, and participate in care planning for cognitively vulnerable patients. Finally, units should consider implementing dementia- or cognitive-friendly environmental adaptations such as clear signage, low-stimulation spaces, and orientation aids that help reduce confusion and enhance patient independence. Collectively, these recommendations highlight that improving care for elderly patients with MCI requires a balanced approach that strengthens individual nurse competencies while simultaneously addressing system-level barriers. By adopting such measures, healthcare institutions can move toward safer, more responsive, and more compassionate care environments that meet the evolving needs of older adults living with mild cognitive impairment.

References

1. Song WX, Wang BR, Tao JH, Li XY, Zhang Y, Li JQ, *et al.* Evidence from a meta-analysis and systematic review reveals the global prevalence of mild cognitive impairment. Front Aging Neurosci. 2023; 15:1227112.
2. Salari N, *et al.* The global prevalence of mild cognitive impairment in geriatric population: a systematic review and meta-analysis. BMC Geriatr. 2025;25: -.
3. da Penha Sobral AIG, Pereira MG, Díaz AP, *et al.* Mild cognitive impairment in the elderly: relationship between communication and functional capacity. Dement Neuropsychol. 2018;12(2):165-172.
4. Lin F, O'Connor C, Ross LA. Caring for older adults with mild cognitive impairment: an update for nurses. J Gerontol Nurs. 2012;38(12):22-35.
5. Anand S, Sabbagh MN. Mild cognitive impairment. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2024.
6. Fogg C, Griffiths P, Meredith P, Bridges J. Hospital

outcomes of older people with cognitive impairment: an integrative review. Int J Geriatr Psychiatry. 2018;33(9):1177-1197.
7. Hendlmeier I, Lohrmann C, Halfens RJG, *et al.* Care challenges in older general hospital patients: impact of cognitive impairment and other patient-related factors. Z Gerontol Geriatr. 2019;52(Suppl 4): S212-S221.
8. Schouten B, Scholtens RM, *et al.* Adverse events in older hospitalized patients with cognitive impairment. J Am Med Dir Assoc. 2025.
9. Ye HMY, Lim Y, *et al.* Hospital nurses' perceived challenges and opportunities in the care of people with dementia: a mixed-methods systematic review. J Clin Nurs. 2024.
10. Pinkert C, Faul E, Saxer S, Burgstaller M, Kamleitner D, Mayer H. Experiences of nurses with the care of patients with dementia in acute hospitals: a secondary analysis. J Clin Nurs. 2018;27(1-2):162-172.
11. Dookhy J, Daly L. Nurses' experiences of caring for persons with dementia experiencing responsive behaviours in an acute hospital: qualitative descriptive research. Int J Older People Nurs. 2021;16(4): e12379.
12. Çevik B, Kav S, Akgün Çıtak E, Akyüz E, Abbasoğlu A. Challenges of providing nursing care to patients with dementia: qualitative research. Eur J Geriatr Gerontol. 2022;4(3):205-211.
13. Kang Y, Kim IS, Kim JE, *et al.* Workload-related issues among nurses caring for patients with dementia: a systematic review. Healthcare (Basel). 2024;12(18):1893.
14. Sun M, Mainland BJ, Ornstein TJ, Sin GL, Herrmann N. Correlates of nursing care burden among institutionalized patients with dementia. Int Psychogeriatr. 2018;30(10):1549-1555.
15. Elzeni BM, Soliman S, Boughdady A. Assessment of communication barriers between nurses and elderly patients. Mansoura Nurs J. 2023;10(1):251-269.
16. Shaw C, Ward C, Gordon J, Williams K, Herr K. Characteristics of elderspeak communication in hospital dementia care: findings from the Nurse Talk observational research. Int J Nurs Stud. 2022; 132:104259.
17. Hartung B, Lalonde M, Vanderspank-Wright B, Phillips JC. New graduate nurses and dementia care in acute care: qualitative research. Nurse Educ Pract. 2021; 53:103049.
18. Jose J, *et al.* Graduate nurses caring for people living with dementia: a scoping review. Dementia (London). 2025; Epub ahead of print.
19. Addis G, Evans D. Nurses' experiences of providing dementia care in acute hospital settings. Nurs Older People. 2025;37(4):27-33.

How to Cite This Article
López M, Mansour AH, Sokolova EP. Challenges faced by nurses in caring for elderly patients with mild cognitive impairment in medical units. Journal of Medicine and Surgical Nursing. 2025;2(2):44-50