Norwegian Nurses’ Reflections Upon Experiences of Ethical Challenges in Older People Care - A Qualitative Thematic Analysis

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Abstract

Background: Many countries face an increasingly older population in need of health care services. There are reports of lack of qualified staff and resources, resulting in poor quality and undignified care. Care quality is dependent upon factors like organization and staffing, but it is also recommended to focus on what staff members experience in clinical practice. In addition, ethical competence is a precondition for high quality care. The aim of this study is to provide knowledge about ethically challenging situations in caring for older people in institutions such as nursing homes and hospitals, and to gain insight into nurses’ written reflections about their experiences and management of ethical challenges in clinical practice.

Methods: The data material consist of reflection notes by continuous education students in advanced gerontology in Norway. Data was collected in 2017–2018. We included 42 of 83 notes and utilized qualitative thematic analysis.

Findings: “Doing what is in the patients’ best interest” is the guiding principle for the participants, portrayed through three themes as follows: a) Meeting vulnerability, discomfort and emotional pain, b) Collaboration with relatives, and c) Struggling to perform professional care. Within each theme, we provide a variety of ethically challenging situations in older people care. The findings represent the participants’ written experiences and reflections upon how they manage the situation and their effort to provide the best possible care.

Conclusions: Health care professionals’ ethical competences may develop when reflecting upon their care performance. Therefore, building ethical competence should be a priority in education of healthcare professionals and in clinical practice. We acknowledge that ethical reflection does not automatically improve care quality, although we find that it fosters increased awareness of one’s action, and as such, it can act as a potential for change.

Implications for practice: How nurses reflect upon and manage challenging situations indicates that quality in care is possible despite scarce resources, and this may contribute to reduce ageism and encourage health care personnel to be willing to work in older people care.

Background

Many countries face an increasingly older population in need of health care services (1, 2). In Scandinavia older people above 80 years are likely to receive help to manage everyday life because of frailty and comorbid diseases, as well as reduced physical and cognitive abilities (3). Ageism in Western societies has influenced upon health care professionals’ attitudes and they often find it less attractive to work in community-based services; ageism has as well adverse impact upon resource allocation and there are reports of lack of qualified staff and poor care quality (4–6). Norwegian research point to undignified patient care in nursing homes (7, 8).
Although care quality is depended upon factors like organization and staffing (9), it is also recommended to focus on what staff members are actually doing and their experiences in clinical practice (10). Quality in older people care also depend upon staff’s ability to make complex, ethical decisions in their practice (11, 12). Ethical competence is a precondition for high quality care, thus there is need for more research in this field (11).

**Ethical challenges in clinical practice**

Nurses encounter daily challenges related to ethical aspects of care; for example related to priority and allocation of care, patient autonomy, or end-of-life concerns (13–15). Furthermore, nurses experience ethical and moral questions in relationships with patients and next of kin, the staff and the health system, and ethically difficult situations occur when the reality does not meet the professionals’ intentions to deliver high quality care (14, 16–18). When staff feel they cannot provide high quality care according to their ethical values, this may result in troubled conscience, feelings of guilt, inadequacy and frustration; leading to workplace stress and risk of burnout, sickness, high turnover and personnel shortage (15, 19). Moreover, low tolerance for failure, limited conversations about difficulties, inflexibility, not giving patients possibilities to utilize their resources or participate in decision-making processes, and also the implicit expectation to be professional and endure aggressive behavior from patients, are found to be ethically challenging when caring for older people (12, 20).

In hospitals, nurses find the complex care situations in acute care settings ethically demanding, and the increasing problem of lack of resources and time to provide high nursing standards of care, can cause frustration and stress (21). The caring needs of older people and especially people with dementia is often not prioritized in hospital settings (22, 23). Nurses in general hospital wards may encounter continuous pressure regarding the prioritizing of patients’ care needs versus managing other tasks on the ward. In addition, nurses experience that their voice is weak when bringing forward their concerns to the doctors (24). Caring for older acutely ill patients with cognitive impairment is very complex, and as acute care environments is often not suitable for frail older patients, nurses’ workload and responsibilities increases (25).

Common ethical challenges reported by nursing home staff are lack of resources, end-of-life issues and coercion (26). There is need for improved ethical competence in nursing homes in order to recognize, reflect upon and solve ethical challenges, and promote professional care that safeguard the respect of the older person (27). Particular attention is given to ethical issues related to palliative care in nursing homes, and the need for improved communication and multidisciplinary approach, and to address staff knowledge (28). A recent review points toward clashing ethical principles in nursing homes, as well as limited resources, communication issues and poor care quality (29).

The best ways to deal with moral issues in patient care is implementing systematic ethics work raising awareness and fostering a climate of openness and dialogue (30, 31). Collective systematic ethics work may foster greater awareness of ethical aspects, personal and professional development, understanding
and respect for colleagues and patients, along with cooperation and new ways to approach difficult situations (13, 32–34). This can be done by ethics reflection groups, as in the Norwegian project in municipal healthcare services which resulted in improvements in these areas; handling ethical challenges, employee cooperation, service quality and relations to patients and relatives (35, 36).

**Ethical reflection in education**

In continuous education, utilizing reflection notes is a way of “writing to learn”, and thus complicated problems may become better understood (37). Ethical reflection helps clarifying beliefs and thoughts, and involves learning through viewing situations in different ways and from new perspectives (38). Reflection may include thinking back on an experience, using mirroring or imagination, and express feelings, insight and alternative perspectives; thus fostering self-knowledge and affirmation of one's professional role, as well as awareness of personal values and prejudices, increase the student's awareness of the inhibiting effect of organizational structures (38–40). The focus upon reflection in continuous education is based on the notion that professionals may develop their clinical expertise, or wisdom (41). Schaefer and Vieira (17) support that professionals’ develop their ethical competences when reflecting upon their own practice. Experienced practitioners often reflect upon their own actions, they examine their taken-for-granted beliefs and are willing to change their practice (42). The knowledge nurses develop after reflecting on situations enable them to link thinking and doing (43), and thus gain increased competence to act in difficult situations.

**Methods**

This is a qualitative study utilizing thematic analysis of written stories. The research team consists of three experienced nurses working in higher education. All three researchers are female and experienced in qualitative research methods.

**Aim**

The study aim is twofold; firstly, providing knowledge about a wide range of ethically challenging situations in caring for older people in institutions such as nursing homes and hospitals; and secondly, to shed light on health care professionals’ experiences and how they reflect upon and manage their ethical challenges.

**Material and participants**

The data material consists of 83 reflection notes by continuous education students in advanced gerontology at a Norwegian Specialized University, collected in 2017–2018. The scholarly assignment is an individual written reflection upon an ethically challenging experience related to work. Almost all participants in this study were nurses, although a few were allied health care professionals; i.e. occupational therapy and professionals caring for people with intellectual disability. We chose not to exclude the few notes written by non-nurses, because their challenges were similar of those experienced by the nurses. Furthermore, all participants were female, and their professional work experience varied
between a few years and above twenty years. Their workplace were mainly home health care and nursing home, and a minority worked in hospital wards. About half of the participants resided in or nearby a larger city; the other came from rural communities on the West Coast, Northern and Southern parts of Norway. We do not provide further details about the participants, in order to support their anonymity.

**Thematic analysis**

Thematic analysis is according to Braun and Clarke (44) a method to identify, analyze and report pattern (themes) in data (p. 79). DeSantis and Ugarriza (45) portray a theme as “an abstract entity that brings meaning and identity to a current experience and its variant manifestations. A theme captures and unifies the nature or basis of the experience into a meaningful whole” (p. 362). Thematic analysis most often interprets various aspects of the research topic and includes the latent descriptions in the text. According to Braun and Clarke (44), there are six phases:

Phase 1) *Familiarizing yourself with your data.* In this phase, all three authors read the notes from the participants, noting down initial ideas and labeled them as preliminary themes. We found that students gain insight into their self-knowledge, values and consequences of actions, thus contributing to the learning outcomes of the scholarly assignments. Then we discussed the themes and decided to focus upon the different ethical challenges and how these were handled, thus we also chose to not focus upon the learning outcome and reflection as a pedagogic measure in this article. The themes related to pedagogic measures were therefore excluded from the further analysis of the texts.

Phase 2) *Generating initial codes.* The authors coded features of the data in a more systematic way searching for data that was relevant to each code.

Phase 3) *Searching for themes.* Here, we collected codes into potential themes and gathered data relevant to each potential theme. The first author put together the suggested themes and sorted the notes. After this, we decided to divide notes into institutional care and home health care, thus excluding notes about home health care. Furthermore, we excluded notes not focusing upon the student’s own performance or workplace or ethics in care (see Fig. 1).

Phase 4) *Reviewing themes.* All authors were checking if the themes were suitable in relation to the codes and to the data set in order to construct a thematic presentation of the findings. In this phase, there were suggestions about five themes and sub-themes.

Phase 5) *Defining and naming themes.* All authors met several times to discuss the conceptualization of the findings and decide upon the final themes. We analyzed each theme trying to catch the overall story of the analysis by giving suitable names for each theme. In this process, we agreed upon three themes without sub-themes.

Phase 6) *Producing the report.* We selected examples that were representative for the final analysis by examples of meaning units. This was a process where we went back to the analysis and then to the research question and the literature, and finally produced a scholarly report of the analysis, as presented in the Findings.

Figure 1. The process of including notes and the analysis
Findings

Our interpretation is that “doing what is in the patients’ best interest” is the guiding principal for the participants, portrayed through three themes as follows: a) Meeting vulnerability, discomfort and emotional pain, b) Collaboration with relatives, and c) Struggling to perform professional care. Within each team, we provide a variety of ethically challenging situations representing the participants’ written experiences and reflections upon how they manage the situation and their effort to provide the best possible care.

Meeting Vulnerability, Discomfort And Emotional Pain

The participants’ main concern was to ensure a good everyday life for their patients. When growing old, it can be challenging to uphold one’s self esteem. One participant wrote about a patient with political engagement who uttered: “It does not matter what I mean”, further explaining: “I am too old”. This participant reflected upon this incident and her own attitudes as follows:

[The patient] declared himself outdated and dismissed as a useful and valuable opinion bearer - based on his chronological age. (...) What attitudes do I signal in my work with older people in nursing homes?

The participant suggested that nurses individually, health services in general and the whole society must demonstrate, both in actions, words and organization, that nursing home residents are an important part of the community, in order to fight ageism.

Moving to a nursing home can be distressing and some patients may experience a great sorrow connected with the loss of functions, and the challenges of adapting to old age's final phase. One participant reflected upon that some patients cope with loss better than others do, and therefore one must find the appropriate interventions to help motivate and build their ability to cope with transitions and enable them to manage as much as possible themselves. Another participant wrote about how demanding it can be to try to alleviate the patients’ emotional suffering:

One morning I cared for a patient who was in a very low mood. I sat down next to him and asked if we could talk. He first told me about his despair over the many things he couldn't do anymore. He could not see any future, since his illness was gradually worsening. I tried to direct the conversation towards what he still managed to do and the joy he experienced when visited by the family. The patient, on the other hand, rejected this, saying: "Why can't you say it the way it is? I don't get any better".

This participant experienced many similar conversations. She managed by trusting her competence; although it was not easy to comfort the patient and she felt uncomfortable to be in the situation, her reflection was that what matters to the patient is for health care personnel to be present and listen.

Quite a few stories related to patients’ discomfort and emotional pain. Our interpretation is that not being able to comfort the patient is very challenging; i.e. witnessing what might be unbearable situations, and
especially end-of-life issues. One participant supported today’s focus upon dying in peace without unduly life-prolonging treatment, however also forwarding her concern that sometimes not offering treatment could be questioned. In her writing she portrayed the situation of a terminal cancer patient. When the patient caught a urinary infection, the doctor and patient agreed upon not to start treatment. The participant disagreed and kept a dialogue with the doctor:

*The next day, the patient was just as ill, and the doctor was contacted again. The doctor then changed his decision and prescribed antibiotics. The result was that the patient became fever-free and avoided this extra discomfort the time he had left.*

Furthermore, the participant pointed to the significance of always “assess holistically whether the goal of the treatment is to cure, to alleviate, or whether treatment is considered pointless or mostly burdensome” when providing end-of-life care.

Another vulnerable matter in institutional care, forwarded by two participants, is the low attention nurses in general pay towards sexual needs in older patients. One participant wrote about her experience as follows:

*In the conversation, the patient says that she misses the good feeling [sexual desire]. I get a little insecure and just listen. I ask her if it is orgasm, she means? She says yes. She wonders how to do it. I say I can help her up in bed and take off her pants, and then she can see if she can satisfy herself.*

This participant reflected upon how nurses have great power over frail and sick people, and that sexual matters may easily be ignored. She managed the situation by listening and try to understand the patient’s thoughts and situation. Furthermore, the participant thought this was important in order to protect the patient’s dignity by recognizing her needs as a human being. The other participant’s reflection was that her meeting with a patient’s sexual needs was “an eye opener” to a subject that many patients keep to themselves; but that can be of great importance. She encourages that healthcare professionals become more courageous and talk about such experiences, thus increasing our understanding and acceptance of patients’ sexual needs and lower the threshold to speak about this theme with colleagues.

There were many ethical challenges regarding dementia and caring for patients with agitation, uneasiness and distress. We find that how to avoid coercion was a main concern. One participant suggested that the personnel do not need to be afraid to give away power and let the patient decide more for themselves. However, quite a few participants wrote about situations where coercion was necessary, as portrayed in this story about a patient with severe dementia:

*The patient has no language and understands poorly. We are two persons because the patient often becomes aggressive during the morning routine. The patient lies in bed, and we see that the sheets are soaked with urine and it is feces in his diaper. (…) He lets us wash his upper body, but when washing his lower body, he becomes angry, and tries to hit and kick us. We must hold his hands to avoid being hit.*
This participant reflected about that holding him was coercive and intrusive; then not being clean is undignified and unhealthy. Subsequently the ward personnel discussed whether they should apply for a coercive decree. However, they experienced many similar situations in the nursing home and found that their care routine differed and discussed issues like environmental measures and trust. They agreed upon that all should provide care in the same way: “After this, we do not need to use coercion, because we have been able to help the patient without him opposing the help.”

Helping patients with activities of daily living often entailed ethical challenges regarding prevention or minimizing the use of coercive interventions. One example is a patient resisting use of a bodysuit as a measure that minimize the spread of resistant bacteria in feces. However, the suit also avoided that the patient uncritically took off his clothes in public areas, sheltering the patient from undignified situations. Another ethical challenge in dementia care is the use of diversion to avoid unrest, and that this might not be though about as coercion. Several participants promoted the importance of creating a good relationship between the nurse and the person with dementia, as well as being conscious of one’s power and how one communicates to prevent aggressive behavior.

Collaboration With Relatives

Finding the right balance of involvement and collaboration with relatives is clearly a challenging area for health care personnel. One commonality is that good communication is important in order to understand the others’ point of view. One participant reflected upon that relatives often put pressure on the need for additional help, although sometimes relatives “may be skeptical about receiving help because they desire to manage on their own.” It is challenging to choose between the wishes of the relatives and the patient’s needs. The participant reflected upon a situation where the patient needed institutional care, was that talking to the husband about why he did not want help was important to help them both; in this particular situation he needed to gain trust in the nursing home personnel being able to provide good care for his wife.

Many stories related to differences in opinion between relatives and health care personnel. One example is a participant who experienced that during a consultation meeting regarding overuse of pain medication, one relative uttered: “I don’t see why we should bother old people, what is there to save? She's old and doesn't have much time left.” This participant also experienced other relatives with the same attitude towards older people and drug use, and she wondered if this reflected a general view of drug use in old age. The participant tried to find out why the patient had pain and contribute to good quality of life. Furthermore, she recommended to develop good cooperation in order to understand each other’s expectations, as well as to “reflect upon one’s own attitudes and professional position in order to be able to meet both relatives and the patient with the necessary information and guidance in the best possible way.”

Involvement of relatives can also be challenging if they are reluctant to participate, or even find it difficult to come visit the patient. This is an ethical challenge, regarding how much and in what ways the
personnel should encourage relatives to visit. One suggestion is to establish good relationships upon admission to the nursing home, and furthermore: “If relatives are unable to keep up with the disease development, it is important to explain to them (...) to allow them time to understand what is going on.” This might lower the threshold to visit patients with late stage dementia. Then, in contrast, there might be challenges when relatives visit frequently, as in this story from a nursing home:

Two relatives visit daily and are present in the kitchen during the evening meal. The conversations are sometimes loud, due to hearing loss in some residents. The noise is disturbing other residents, and some get upset.

To manage the situation, the participant suggested to gather staff, and if possible, also include the relatives to elucidate the ethical dilemma, discuss and evaluate; finding a solution that is the best for as many people as possible. Furthermore, the staff must have a consensus on what the solution should be and practice this similarly, regardless of who is on duty.

One of the areas providing the greatest ethical challenges is how to involve relatives in end-of-life decisions and how to support them when the patient is dying. The participants often experienced that relatives have questions about intravenous fluid therapy, probe nutrition and the like. They suggested that such matters must be clarified as early as possible, helping relatives to be better prepared for the end-of-life period. Treatment with antibiotics in frail older patients were a particularly problematic issue, as portrayed in this story:

The patient is going to die. I ask a colleague to call her relatives. She dies half an hour later. When the son arrives, he is grateful that his mother did not die alone, but he is sorry for one thing. Five days before, antibiotics therapy was started based on a slightly elevated CRP. He had clearly expressed that this was nothing his mother wanted. He thought she should avoid active treatment as she had recently become worse with increased swallowing difficulties and reduced appetite. I knew the patient well and was surprised that they had started antibiotics therapy.

The participant reflected upon that in this case palliative care might have been the best, as the patient “had avoided eating crushed antibiotic tablets in jam as her last meal”.

It appeared in many stories that when patients do not respond to medical treatment and palliative treatment for the last days of life is initiated, both the patient and the relatives are informed. The ward personnel look after patients and relatives in the best possible way. In such situations, relatives being present is a great resource, providing care that professionals cannot. In situations where patients do not have relatives, one participant suggested: “A volunteer could sit with the patient and offer the little extra that no employee has the opportunity to do.” However, the patient’s relatives were often present during the terminal phase, and this can be a strain or even a chock for many family members. One participant reflected upon that even though the relatives are present and informed about the situation, they might still not understand. Another participant wrote:
I stand by the bed of a dying patient. When the relatives enter the room and see their mother, they begin to cry. One son says: “There must be something that can make mother better, she should be hospitalized!” I calmly replied: “No, unfortunately. Now we will alleviate the discomfort she may have and be with her.”

The participant was amazed by the question because they had several conversations with the patient and relatives. This experience made her more aware of her role as a professional and that “conversations about the end phase of life are very demanding for those involved and that it differs what is understood.” Her recommendation was to give precise information and be prepared for the family to be in a crisis that might appear “both through anger, crying, despair and denial.” Moreover, one should communicate with open-ended questions, being conscious of thoughts relatives have, and not assume they understand the situation.

**Struggling To Perform Professional Care**

Collaborating with other health care services may create ethical challenges, like transfer of patients from the hospital to the nursing home at night. However, the participants’ main concern was how to provide professional, individualized care. Such personalized care is often a question of closeness in the caregiver-patient relationship. Also, this relies upon how well the caregiver knows the patient, as well as the caregivers’ knowledge level and expertise. One participant portrayed her development like this:

*As a nurse in older people care, I have changed and developed in my professional practice. What has changed the most is how close I dare to be to the patient. (...) I can assess who needs or wants a hug and when it is appropriate to hug. Moreover, I have seen the impact. The good warm look from the patient after she or he gets a hug, the lightness that settles in the body, pain that becomes less prominent. (...) A patient expressed how happy she was for a hug she got from an employee and said: “We older people need love; we need this human compassion.”*

Another participant wrote: “*Getting to know the patient and hearing about what life is like and what life has been like can be the entrance to the patient’s feeling of security, tranquility and being seen.*” She puts forward that listening to the patient’s experiences and stories is important for both the patient and personnel, and that we need to make room for this despite busy shifts.

Many participant stories related to patients with dementia; experiencing altered personality and loss of control of one’s behavior can be a great sorrow that rocks the very identity of the person. To treat patients with respect is of outmost importance, but the challenge is to be conscious of one’s own behavior. It is also important that health care personnel are aware of their own attitudes towards the patient. When others talk about a patient as “burdensome”, one can become prejudiced, as this participant portrays:

*At first, the relationship between me and the patient was distanced. I probably signalized a distance without being aware of this. But one day I decided to try to get to know the person behind the diseases. (...) I started by stopping by his room each shift, without him calling for help, to have a small chat.*
became familiar with the patient in a different way. (...) Eventually we got a good relationship and I cared for him with pleasure.

Moreover, there were many ethical challenges regarding autonomy and the involvement of the patient in decision-making. One participant forwarded that although acute care has no age limit, we need to consider if all interventions are necessary, and this can be even more difficult regarding patients with dementia who cannot express their opinions. Another challenge regarding autonomy is when the decision made is not according to the personnel's expectation. In one story, the patient had diabetes, and when the doctor allowed the patient to eat biscuits, some of the personnel were against it and wanted to replace it with a sugar-free biscuit. In such situations, one participant pointed to that we must regard what the patients themselves want and remember that we as health professionals cannot assume that we always know what is “best for the patient”.

The participants believed they should ask the patients more often about their wishes and facilitate their individual needs. However, the findings highlight that the participants also struggle to accept that patients might wish to do something that is not in accordance with health recommendations, for example to keep smoking when suffering from lung-disease. As one participant writes: “The right to health care does not trigger an obligation to receive it.”

Furthermore, we also find the well-known tension between the institution as the patients' home and at the same time; it is the workplace for the personnel. Thus, institutional routines might limit the possibility for individual adaptations. There are also quite a few stories of poor care related to lack of resources and organizational matters. One participant wrote about bad consciousness because of not being able to fulfill her wish to be with a dying patient: “I would have liked sitting with the patient, holding her hand and making sure she did not die alone. Due to low staffing, it was impossible to do so.”

A few notes related to prioritizing when two or more patients need attention at the same time. Such situations cause ethical challenges if there are not enough personnel resources, and one participant described how her prioritizing was influenced by both “pressure from the manager and concern about the many other patients and tasks waiting”. At night, in a busy hospital ward, the use of sedatives can be an ethical challenge, if it is used only to avoid falls at night. Similarly, other participants wrote about giving medication in replacement of time to be with patients, as in this story:

One evening shift a patient got out of bed several times and went out in the cold winter night in her night gown. She only wanted to take an evening stroll; she said each time I got her back. In the end, I did not see other alternatives than giving her the medication Sobril. I sang for her and she quickly fell asleep with her hand in my hand. I was very sad, for I felt I sedated her. This gave me a bad conscience; she just wanted an evening walk. Still, I thought medication was the best solution.

Afterwards, the participant reflected about how to improve their care; they would like the patient to walk outdoors but feared that she would get lost. Furthermore, the participant suggested how to manage such
challenges: “There is a great need for volunteers in health care as most of our daily work-shifts are busy and is primarily used to meet the need for basic nursing care.”

Several participants reported about feeling vulnerable when being alone on duty without someone to consult with. One participant wrote: “As a nurse, I experience that my values often are challenged due to time pressure and lack of other professionals to support me in demanding situations”. These participants suggest employing more personnel that are qualified, enabling the nurse to work differently and be present with the patients in a better way.

Discussion

This study provides insight into health care professionals’ experiences of ethically challenging situations in caring for older people and how such challenges might be managed. Nurses in hospitals and nursing homes oversee the care for patients. Because older people often are vulnerable, the power asymmetry gives the nurse a responsibility to act in ethically adequate ways (20, 46). We find that the guiding principle in this study is “doing what is in the patients’ best interest”. This is in accordance with the ethical concept beneficence; actions intended to doing good or benefit other people (47).

Meeting vulnerability, discomfort and emotional pain

Older patients may become vulnerable due to frailty and losses (46). However, based on our findings, the often-unconscious ageist attitudes found both in older people themselves and in personnel, may too lead to situations where older people feel vulnerable. Thus, we agree upon the importance to fight ageism (6). Furthermore, prerequisites for ethically based daily care are being positive towards the older person, and seeing the person behind the illness and suffering (48). The participants in this study were concerned about providing comfort and alleviate suffering in older people and appeared to have the patient’s perspective at the center of their care. Especially challenging were emotional suffering and distress regarding moving to a nursing home or adaption to the final phase of old age, and just being present and listen were presented as the best possible nursing care. Our interpretation is that the participants try to care for the whole human being and thus safeguard their dignity (49).

Finding the best solution for the patient was a main concern in this study. A few participants pointed to that expectation from leaders sometimes limited their ability to decide for themselves what is in the patient’s best interest. More common were issues regarding collaboration with colleagues and other disciplines, which can be challenging when there are conflicting opinions. Several participants expressed feeling vulnerable in the professional relationship with doctors; this can be due to being hierarchically subordinated in status (20). Our participants experienced being unable to argue for their views, and that they were not listened to or unable to convince the doctors (24). Interprofessional collaboration promotes better patient outcomes, however nurses’ humanistic value base may have weakened the place in healthcare hierarchies and thereby limited the ability of nurses to dialogue with doctors about their concerns and opinions (50).
It is important to pay attention to everyday ethical challenges (31). One issue described by two participants were sexual needs in patients. Sexual health in older adults is still somewhat neglected (51), and our participants forward that nurses need to put into words what they experience, although it can be difficult. Other research (52, 53) support more guidance for personnel and suggest an ethical approach to sexuality in older adults.

The findings imply that helping patients with intimate care and other activities of daily living can be troublesome, and often rises ethical challenges regarding coercive interventions. In Norwegian nursing homes, there has been extensive use of coercion and several studies report on how to reduce such practices (54–56). Coercion or restraint is a common ethical challenge in older people care, and programs aim to enhance care quality by implementing alternative strategies both in nursing homes and in acute care settings (57, 58). Avoiding or minimize the use of coercion were the focus in our study.

**Collaboration with relatives**

Ethical challenges relating to patients’ relatives are common (16), and the participants in our study found that the relationship with relatives can be demanding in both hospitals and nursing homes. There are a few stories about difficulties relating to relatives in daily life, whereas both “too much” and “too little” involvement can be challenging. In situations with severe illness or cognitive decline in the older person, it can be difficult to know what the patient wants, and relatives can be helpful. Especially in care for people with dementia, relatives can ensure quality of care based on their knowledge and emotional bounds with the patient (59). The participants experienced that understanding the others’ point of view, establishing good communication and information about how the patient is doing were significant in order to collaborate well with relatives.

Particularly end-of-life situations were demanding, and most common were conflicts about whether active treatment should be given or not. Most challenging were situations where the family did not understand that the patient was dying and requested treatment like intravenous fluid or tube feeding. Collaboration strategies to ensure quality care and systematic involvement of relatives are needed in both nursing homes and acute hospital wards (60, 61). Our interpretation is that we should better define the role of relatives; what is the extent to what they should be involved in, and who should decide what is the best interest of the patient? We suggest further research to better understand the borders between relatives’ responsibilities and the duties of health care personnel.

**Struggling to perform professional care**

Our findings portray how the participants strive to provide professional, individualized care. This can be fostered by experiencing closeness in the caregiver-patient relationship, like in the story of the participant describing her personal development towards understanding the importance of giving her patients’ a hug. Other participants pointed to the need to take time to talk to patients and get to know their life history, which is found to improve the care quality (62). We understand it can be an ethical challenge to make room for such care. However, giving a hug does not need to take much time, and small acts of affection is important for many older people (63).
Moreover, we find that written reflection upon their own care, thoughts and actions, seemingly rise awareness of attitudes towards the patients, like in the story of prejudicialness. Greater awareness of ethical issues is found to foster ethical nursing standards in older people care (46). Caregivers with awareness of their own ethical values can make conscious decisions “to do well and to do right” in challenging situations (48).

Another common challenge was supporting the free will of patients, involving them in decisions. Autonomy and respect for the older persons’ opinions is part of safeguarding their dignity, and this constitutes one of the major ethical caring challenges (48). Older patients should be invited to participate (26). However, research point to similar barriers as we found in this study; unethical attitudes by co-workers, routines and rules, the behavior of co-residents, the attitudes of older people themselves, and the nature of the patients’ health and dependency (64). Another limit of the free will of patients found in our study is the reluctance by health care personnel to accept the wishes of the patient if it is against their own professional judgment, i.e. not quit smoking or giving biscuits to a patient with diabetes.

Our findings suggest that nurses often find themselves in situations where they must balance the need of several patients and prioritize who should receive their attention, and they were sometimes unable to provide care at the standard they had preferred. An intensified work load without the necessary increase of resources, personnel or time, may lead to nurses being forced to decide what care to give, and what care to leave out (15). We support the idea that volunteers should be integrated into the care of older people, as suggested by participants in our study. Volunteer programs in both acute hospitals (65) and long-term facilities (66) is found to impact positively upon patents’ health and well-being. Nevertheless, we acknowledge the need for more qualified staff, and especially young nurses in our study wished for collegial supervision from more experienced health professionals, when encountering challenging situations. It is not only need of sufficient qualified staff with knowledge about older people care; also the role of the nurse in older people care must be improved (67).

Methodological consideration and limitations

The authors discussed different points of views and reached agreement about the themes and sub-themes, and this strengthens the credibility (68) of the analysis. Furthermore, regarding aspects of trustworthiness (68), we portray a variety of practice situations and include many narratives and text quotes to strengthen the study’s authenticity. However, our data were collected “second hand” through reflection notes, this can limit the study’s confirmability. We find that the number of reflection notes were satisfactory, regarding both the breadth of themes and the commonalities found across the notes. Because of the notes being limited to approx. 500 words, we found the number of notes manageable for thematic analysis and our co-operation in the research process. The choice to limit this article to practice settings in institutions, made it easier to focus the article, yet it has limited the usefulness of this study regarding non-institutional care. Although qualitative research is perceived as suitable in the field of clinical ethics (69), we acknowledge that the nature of qualitative research means that it cannot be generalized. Other researchers assert that the similarities of nursing globally, suggest that parts of
qualitative findings can be transferable between healthcare settings (16). Therefore, we find it likely that countries with similar care services as Norway, may find some transferable knowledge from this article.

**Conclusions**

Our findings point to that health care professionals strive to “do what is in the patients’ best interest”, and this is fostered through collaboration, professionalism, care and presence. Health care professionals’ ethical competences may develop when reflecting upon their own care performance, therefore building ethical competence should be a priority in education of healthcare professionals and in clinical practice. We acknowledge that ethical reflection does not automatically improve care quality, although we find that it fosters increased awareness of one’s action, and as such, it can act as a potential for change. This study has provided insight into how nurses reflect upon and manage challenging situations. This indicates that quality in care is possible despite scarce resources, and these experiences may contribute to reduce ageism and encourage health care personnel to work in older people care.

**Declarations**

*Ethics approval and consent to participate*

Because of no recording of sensitive data, this project was not required to apply for ethical review board approval (70). The participants were informed verbally and in writing of the intention of this study, which were to publish a paper based on their reflection notes. All participants gave written consent, and a guarantee of anonymity and confidentiality was given. The study followed the ethical research standards at the involved Specialized University.

*Consent for publication*

Not applicable.

*Availability of data and materials*

The material is available upon request to the first author.

*Competing interests*

The authors declare that they have no competing interests.

*Funding*

The study received no funding.

*Authors’ contributions*
LR collected data and was main responsible for the qualitative analysis and drafted the manuscript. LR, ALH and MHH participated in all phases of the analysis and read and approved the final manuscript.

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**Figures**

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**Figure 1**

The process of including notes and the analysis
Supplementary Files

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- COREQchecklistBMCMedicalEthics.pdf