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

Linda Rykkje, PhD, RN, MNSc[1], Anne Lise Holm, PhD, RPN, MPSc[2], and Marit Helene Hem, PhD, RPN, MHSc[3]

Abstract

Introduction: Internationally, aging populations have increased needs for health care services, and often specialized care is required. However, services for older people tend to be underfunded, resulting in lack of qualified staff and poor quality care. Resource shortages lead to ethical challenges and insufficient nursing care. Therefore, quality in daily care for older people also depends upon the nurses' ability to make complex, ethical decisions in their practice.

Objectives: To explore ethical challenges experienced by nurses caring for older people in clinical practice, and to provide examples of management for the challenges.

Methods: The data collected were written reflection notes by Norwegian continuous education students in advanced gerontology. Forty two of 83 notes were included and a thematic analysis in six steps was utilized.

Findings: There are three main themes: (1) meeting vulnerability, discomfort, and suffering, (2) collaboration with relatives, and (3) struggling to perform professional care.

Conclusion: Nurses strive to "do what is in the patients' best interest", and this is fostered through collaboration, professionalism, care, and presence. Nurses' ethical competencies may develop when reflecting upon their own care performance. Building ethical competencies should be a priority in both nursing education and clinical practice. However, to improve care quality, nurses also need professional knowledge about older people care and ethical awareness should be supported by the workplace.

Keywords

qualitative research, ethical challenges, reflections, older people nursing

Introduction

There is a global increase in the older population need for nursing care services. Some people over 80 years of age may need help to manage everyday life related to frailty and comorbid diseases, as well as reduced physical and cognitive abilities (Lütz, 2017). Norwegian services for older people are provided by 356 municipals and are based on people's needs and not their ability to pay (Sogstad et al., 2020). The Norwegian coordination reform reflects the global trend of shorter hospital stays, thus older people care has become more complex and municipal care services more specialized (Næss et al., 2017; Sogstad et al., 2020).

The nursing profession is a critical part of care services (Haddad et al., 2020) and is expected to meet the complex needs of older people. However, Norwegian nurses are often alone on their shifts with the overall responsibility for patient care, leaving them vulnerable to stress and work overload. Bratt and Gautun (2018) found in a survey of Norwegian nurses that 25% wished to leave older people care and equally as many were uncertain due to unfavorable

[1]Faculty of Health Studies, VID Specialized University, Bergen, Norway
[2]Faculty of Health and Social Sciences, Western Norway University of Applied Sciences, Haugesund, Norway
[3]Faculty of Health Studies, VID Specialized University, Oslo, Norway

Corresponding Author:
Faculty of Health Studies, VID Specialized University, Ulriksdal 10, 5009 Bergen, Norway.
Email: linda.rykkje@vid.no

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working conditions. Today, there is a nursing shortage and many nurses tend to leave the profession (Goodare, 2017; Haddad et al., 2020). A literature review on nurses' experiences of ethical dilemmas, concludes that "practice is challenged by organizational structures and the development of the health care system, inhibiting nurses' professional decision-making and forcing them to compromise basic nursing values" (Haahr et al., 2019, p. 259). Therefore, further knowledge not only about nurses' experiences of ethical challenges but also how these might be met, could help mitigate nurses choosing to leave older people care.

Despite increased demands, ageism has negatively impacted resource allocation, resulting in a lack of qualified staff and poor care quality (Gautun & Grødem, 2015; Wilson et al., 2017). Ageism arises "when age is used to categorize and divide people in ways that lead to harm, disadvantage, and injustice. It can take many forms including prejudicial attitudes, discriminatory acts, and institutional policies and practices that perpetuate stereotypical beliefs" (World Health Organization, 2021). The underfunding of municipal health care services leads to ethical challenges and insufficient nursing care (Heggestad & Førde, 2020; Slettebø et al., 2018). Therefore, quality care also depends upon nurses' ability to make complex, ethical decisions in their practice (Frilund et al., 2014; Koskenvuori et al., 2019).

One guiding principle is the ethical concept of beneficence, which are the actions intended to be "doing good" or benefit other people. Beneficence implies not merely avoiding doing harm; attention must be paid to human welfare and providing benefit to the older person. Beneficence also requires the nurse to consider the principle of utility, which means to balance benefits, risks, and costs to find the best overall results (Beauchamp & Childress, 2013). Furthermore, it is important to consider a theoretical fundament for nursing ethics, as focusing upon ethical principles, norms, rules, and regulations to govern nursing is insufficient. What is needed, according to Östman et al. (2019), is to consider ethics and health from an ontological perspective, where the ethos of freedom and responsibility is found to be central to nursing care.

Review of Literature

Nurses must act according to what is in the best interests of the older people being cared for. In the literature, there is much written about challenges in clinical practice, but less about how to solve those challenges. Therefore, literature about ethical reflection in education is included, with emphasis on reflective writing as a method to develop ethical competencies.

Ethical Challenges in Clinical Practice

Nurses encounter ethical challenges related to priority and allocation of care, patient autonomy, and end-of-life concerns (Rasoal et al., 2016; Suhonen et al., 2018). Furthermore, nurses experience ethical and moral questions in relationships with patients and their next of kin and the staff, and the health system. Difficult situations occur when reality does not meet the professionals' intentions to deliver high-quality care (Rasoal et al., 2016; Schaefer & Vieira, 2015; Tønnessen et al., 2016). 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 (Frilund et al., 2014; Nordström & Wangmo, 2018).

In **hospitals**, nurses find the complex care situations in acute care settings ethically demanding, and the lack of resources and time to provide high nursing standards of care can cause frustration and stress (Sørlie et al., 2004). 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 (Storaker et al., 2019). Caring for older acutely ill patients with cognitive impairment is very complex, and acute care environments are often not suitable for frail older patients, thus nurses' workload and responsibilities increase (Nilsson et al., 2016).

Common ethical challenges reported by **nursing home** staff are lack of resources, end-of-life issues, and coercion (Bollig et al., 2015). There is a need for improved ethical competence in nursing homes to recognize, reflect upon, and solve ethical challenges, and promote professional care that safeguards the respect of the older person (Kiljunen et al., 2019). A review points toward clashing ethical principles in nursing homes, as well as limited resources, communication issues, and poor care quality (Preshaw et al., 2016). One way to deal with moral issues is implementing systematic ethics work that fosters a 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 (Bollig et al., 2017; Magelssen et al., 2018).

Ethical Reflection in Education

In continuous education, utilizing reflection notes is a way of "writing to learn" and complicated problems may become better understood (Coleman & Willis, 2015). Reflective writing helps clarify beliefs and thoughts and involves learning through viewing situations in different ways and from new perspectives. Reflection may include thinking back on an experience, using mirroring or imagination, expressing feelings, insight, and alternative perspectives. Reflection fosters self-knowledge and affirmation of one's professional role, as well as awareness of personal values and prejudices.

Awareness of the inhibiting effect of organizational structures increases the nurse's experience (Asselin et al., 2013).

The focus upon reflection in continuous education is based on the notion that professionals may develop their ethical competencies when reflecting upon their own practice (Rykkje, 2017; Schaefer & Vieira, 2015). Reflective writing is found to enhance nurses' ethical reasoning, including communication skills, collaboration with patients and families, changing negative attitudes, improved ability to prioritize care, awareness of roles and responsibilities, and validation of their decision (Bjerkvik & Hilli, 2019).

Objectives

Because ethical competence is a precondition for high-quality care, there is a need for more research in this field (Koskenvuori et al., 2019). It is also recommended to focus upon what health care staff members do and their experiences in clinical practice (Backhaus et al., 2018). Therefore, the study aim was to explore ethical challenges experienced by nurses caring for older people in clinical practice, as well as to provide examples of management of such challenges.

Methods

Design

This was a qualitative study utilizing thematic analysis of written stories. The research question was: *How do nurses experience and manage ethically challenging situations in caring for older people*? In the analysis process the authors chose to narrow the focus to institutions such as nursing homes and hospitals.

Thematic analysis is according to Braun and Clarke (2006) a method to identify, analyze, and report patterns (themes) in datasets. Furthermore, Braun and Clarke assert that it is important to present the assumptions about the nature of the data. In this study, a section on reflective writing in education was included in the review of literature.

Data Collection and Participants

In qualitative research, written stories can be a useful source of data. The first author is responsible for an interdisciplinary continuous education in advanced gerontology, providing 60 European Credit Transfer System (ECTS) with the duration of four semesters, at a Norwegian University. One scholarly assignment is an individual written reflection, limited to 500–800 words, upon an ethically challenging experience related to clinical practice. The reflection notes were considered being rich data material for exploring current ethical challenges that nurses experience in older people care. Because written reflections might often bring forward tacit knowledge and give voice to ethical expertise (Rykkje, 2017; Schaefer & Vieira, 2015), the notes were useful for exploring how nurses might manage their challenges.

Two different courses held in the fall of 2017 and the fall of 2018 were included. Forty students attended one course and 28 students attended two of the courses; all were asked by the first author for permission to use their notes in research after the course was ended, that is, the following semester. Therefore, students were not aware of their possible participation during the writing of the assignment. Five students chose not to participate, and they were not asked why. Sixty-three students agreed to participate and a total of 83 reflection notes were collected. Three notes written by non-nurses were excluded for the purpose of this article, resulting in 80 notes before starting the analysis.

All participants were female, their professional work experience varied between a few years and more than 20 years; their workplaces were mainly nursing home facilities or home health care, and a few worked in hospital wards. About half of the participants resided in or nearby a larger city; the others came from rural communities on the west coast, northern and southern parts of Norway.

Consent to Participate and Research Ethics

The students were informed about the intention of this study before giving written consent to participate. After students consented to their notes being used, all identifiable information was removed to secure confidentiality. This study followed the 2017 guidelines of The Norwegian Data Protection Authority but was at that time not eligible to apply for approval because of no record of personal data (NSD—Norwegian Centre for Research Data, 2020). The involved University does not have an Ethics Board; therefore, the study was approved by the institutional leader.

Thematic Analysis

The authors applied Braun and Clarke's (2006) notion about a theme capturing "something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (p. 82). A rich description of the findings was chosen and an inductive type of analysis where themes are strongly linked to the data themselves. The analysis was a process in six phases (Braun & Clarke, 2006):

- **Phase 1:** All three authors read the 80 notes from participants, noting down initial ideas and marked them as preliminary themes. The authors found that students gain insight into their self-knowledge, values, and consequences of actions, thus contributing to the learning outcomes of the scholarly assignments. The themes were then discussed, and the authors decided to focus upon the different ethical challenges and how these were managed. It was decided 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 further analysis of the texts.

- **Phase 2:** The authors coded features of the data in a more systematic way searching for data that was relevant to each code.
- **Phase 3:** Codes were categorized into potential themes with data relevant to each potential theme. The first author put together the suggested themes and sorted the notes. After discussion, the authors decided to divide notes into institutional care and home health care, excluding 16 notes about home health care. In addition, 22 notes lacking reflection upon ethics in care were excluded.
- **Phase 4:** Of the 42 remaining notes, 33 related to ethical challenges in nursing homes and nine to hospital settings. All authors were checking if the themes were suitable in relation to the codes and to the dataset to construct a thematic presentation of the findings. In this phase, there were suggestions about five themes and subthemes.
- **Phase 5:** All authors met several times to discuss the conceptualization of the findings and decide upon the final themes. In the analysis of themes, the authors worked toward catching the overall story of the written stories and each theme was given suitable names. After several rounds of discussions, the authors finally agreed upon three themes with subthemes.
- **Phase 6:** In this phase quotes that were representative for the final analysis by examples of meaning units were selected.

Findings

The findings are portrayed through three themes with two–four subthemes as shown in Table 1.

Table 1. Themes and Subthemes.

Main themes	Subthemes
Meeting vulnerability, discomfort, and suffering	• Loss in old age • Alleviate suffering • Supporting sexual needs • Avoiding coercion
Collaboration with relatives	• Understanding each other • End-of-life decisions
Struggling to perform professional care	• Closeness to the patient • Involvement of the patient • Lack of time and resources

Meeting Vulnerability, Discomfort, and Suffering

The participants' main concern was to ensure a good everyday life for their patients.

Loss in Old Age

Moving to a nursing home can be distressing and patients may experience a great sorrow connected with the loss of functions and adapting to old age's final phase. 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?*

It was 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, to fight ageism.

Alleviate Suffering

Quite a few stories related to patients' discomfort and suffering. Not being able to comfort the patient is very challenging like witnessing what might be unbearable situations, and especially end-of-life issues. One participant wrote about how demanding it can be to alleviate the patients' emotional despair:

> *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 could not 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 in the situation. Several participants reflected upon similar matters and found that what matters to the patient is for health care personnel to be present and listen.

Supporting Sexual Needs

Another vulnerable matter in institutional care, forwarded by two participants, is the low attention nurses in general pay toward sexual needs of 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 trying to understand the patient's thoughts and desires.

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 health care professionals to become more courageous and talk about such experiences, thus increasing understanding and acceptance of patients' sexual needs and lower the threshold to speak about this theme with colleagues.

Avoiding Coercion

There were many ethical challenges regarding dementia and caring for patients with agitation, uneasiness, and distress. It was suggested 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. Care takes 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 that holding him was coercive and intrusive; yet not being clean is undignified and unhealthy. Subsequently, the ward personnel discussed whether they should apply for a coercive decree (a formal decision of forced treatment and care, sent to the County Governor's Office, cf. Gjellestad. et al., 2021). However, they experienced many similar situations in the nursing home and found their care routine differed, and therefore discussed issues like environmental measures and trust. They agreed 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.*"

Collaboration with Relatives

Finding the right balance of involvement and collaboration with relatives is a challenging area for nurses.

Understanding Each Other

A commonality across the stories is that good communication is important to be able to understand the others' point of view. Relatives often put pressure on the need for additional help, although it can also be challenging to choose between the wishes of the relatives and the patient's needs if they are "*sceptical about receiving help because they desire to manage on their own.*" Furthermore, understanding relatives' perspective 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*.

Several stories related to differences in opinion between relatives and health care personnel. One example is a participant who experienced 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 toward older people and drug usage and wondered if this reflected a general view in society. There were many similar stories about differences in opinion about care when older people become frail and enter the last phase of life.

End-of-Life Decisions

One of the areas providing the greatest ethical challenges was 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, tube feeding, and the like. It was 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 was 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 started based on a slightly elevated CRP* [C-Reactive Protein test]. *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*.

The participant reflected 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, palliative treatment for the last days of life is initiated. 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, even though the relatives are informed and present during the terminal phase, they might still not understand; the situation can be a strain or even a shock for many family members. One 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 had several conversations with the patient and relatives about the situation. This experience made her more aware of her role as a professional: "*conversations about the end phase of life are very demanding for those involved and 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*."

Struggling to Perform Professional Care

How to provide professional, individualized patient care was a major ethical challenge experienced by the participants.

Closeness to the patient

Providing 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 how she had changed and developed in her 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, tranquillity and being seen.*" She put forward that listening to the patient's experiences and stories is important for both the patient and personnel, and that nurses need to make room for this despite busy shifts.

To treat patients with respect is of outmost importance, and health care personnel must be aware of their own attitudes toward the patient. When others talk about a patient as "burdensome", one can become prejudiced, as this participant portrayed:

> *At first, the relationship between me and the patient was distanced. I probably signalled 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. I became familiar with the patient in a different way. (…) Eventually we got a good relationship and I cared for him with pleasure.*

Involvement of the patient

There were many ethical challenges regarding autonomy and the involvement of the patient in decision-making. Although acute care has no age limit, nurses 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 regular biscuits, some of the personnel were against it and wanted to replace it with a sugar-free biscuit. In such situations, health professionals must respect what the patients themselves want and remember that nurses cannot assume they always know what is "*best for the patient*".

Asking the patients more often about their wishes and facilitating their individual needs were highlighted. However, some participants also struggled 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. One participant reflected upon respect for patient autonomy as follows: "*The right to healthcare does not trigger an obligation to receive it."*

Lack of time and resources

Institutional routines could limit the possibility for individual adaptations. There are also quite a few stories related to lack of resources and organizational matters. One participant wrote about bad consciousness caused by being unable 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 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* [oksazepam]. *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.*

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

Several participants reported 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*".

Discussion

The study focus was upon nurses' reflections on experiences and management of ethically challenging situations. Because older people often are vulnerable, the power asymmetry gives the nurse a responsibility to act in ethically adequate ways (Nordström & Wangmo, 2018; Suhonen et al., 2010). The guiding principle for the participants in this study was "doing what is in the patients' best interest", which is in accordance with *beneficence*; actions intended to be doing good or benefit other people (Beauchamp & Childress, 2013). Using written reflection, nurses became aware of their own ethical values and how these were contested in challenging situations. If nurses only focus on external sides of ethics in care, core values of nursing like freedom, responsibility, and compassionate care can be restricted, and care can become procedural (Östman et al., 2019).

Meeting Vulnerability, Discomfort, and Suffering

Older patients may become vulnerable due to frailty and losses (Suhonen et al., 2010). However, 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, the authors agree upon the importance to fight ageism (Wilson et al., 2017). Prerequisites for ethically based daily care are being positive toward the older person and seeing the person behind the illness and suffering (Frilund et al., 2013).

The participants in this study were concerned about providing comfort and alleviate suffering (Eriksson, 1992) in older people and appeared to have the patient's perspective at the center of their care. Especially challenging was emotional suffering and distress, and just being present and listening were presented as the best nursing care. The interpretation is that the participants try to care for the whole human being and thus safeguard their dignity (Rykkje & Råholm, 2014). Finding the best solution for the patient was a major concern and expectations from leaders, as well as collaboration with colleagues and other disciplines, can be challenging when there are conflicting opinions. Several participants expressed feeling vulnerable in the professional relationship with doctors, finding it difficult to argue for their views, or that they were not listened to or unable to convince the doctors (Nordström & Wangmo, 2018; Storaker et al., 2019). To balance between harm and care in difficult situations were also highlighted by Haahr et al. (2019); ethical dilemmas cause stress if nurses are forced to provide care that collides with professional opinions or values.

Bollig et al. (2017) point to the importance of paying attention to everyday ethical challenges and include patient's wishes. One issue described by two participants was sexual needs in patients. This type of "taboo" subject is ethically challenging regarding balancing patients' needs and wishes, and the limitations that come with institutional care. Sexual health in older adults is still somewhat neglected (Træen et al., 2019), and the authors support the participant's opinion that openness and knowledge is needed to find solutions that safeguard both the patients' and staff's vulnerability and personal boundaries.

Regarding respect for autonomy (Beauchamp & Childress, 2013), this was a struggle in many stories, especially in care for people with dementia. The findings imply that helping patients with intimate care and other activities of daily living can be troublesome, often raising ethical challenges regarding coercive interventions. In nursing homes, there has been extensive use of coercion and a subsequent focus upon how to reduce such practices (Øye et al., 2017). The use of coercion is regulated by Norwegian legislation and avoiding or minimizing the use of coercion was emphasized by the participants in this study.

Collaboration with Relatives

Ethical challenges relating to relatives are common (Tønnessen et al., 2016), and the participants in this study found that 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 (Helgesen et al., 2015). The participants experienced that understanding the others' point of view and establishing good communication and information about how the patient is doing was significant to collaborate well with relatives.

End-of-life situations were particularly demanding, and most challenging were situations where the family did not understand that the patient was dying. Therefore, collaboration strategies to ensure quality in care and systematic involvement of relatives are needed in both nursing homes and acute hospital wards (Sivertsen et al., 2018). The authors suggest to better define the role of relatives and to what extent they should be involved. There is need for research to better understand the borders between relatives' responsibilities and the duties of health care personnel.

Struggling to Perform Professional Care

These findings portray how professional, individualized care can be fostered by knowing the patient and experiencing closeness in the caregiver–patient relationship like in the story demonstrating the importance of giving a hug. Also highlighted was finding time to talk to patients and get to know their life history, which can improve care quality (Doran et al., 2019). It can be an ethical challenge to make room for such care. However, giving a hug does not take much time, and small acts of affection are important for many older people (Rykkje & Råholm, 2014). Nurses reflect upon their own care, thoughts, and actions to raise awareness of attitudes toward the patients like in the story of prejudicialness. Other studies support the knowledge nurses develop after reflecting on situations enable them to link thinking and doing, and thus gain increased self-efficacy and ethical competence (Bjerkvik & Hilli, 2019; Obeid & Man, 2020). Greater awareness of ethical issues in older people care can enable nurses to make conscious decisions "to do well and to do right" in challenging situations (Frilund et al., 2013; Suhonen et al., 2010). Building ethical awareness at the workplace using systematic reflection groups supported by leaders and the collegium is recommended (Bollig et al., 2017; Magelssen et al., 2018).

Another common ethical challenge was supporting the free will of patients, and involving them in decision-making (Beauchamp & Childress, 2013). Respect for the older persons' opinions is part of safeguarding their dignity, and this constitutes one of the major ethical caring challenges (Frilund et al., 2013). Older patients should be invited to participate (Bollig et al., 2015). However, research points to similar barriers as 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 (Tuominen et al., 2016). Another limit of the free will of patients found in this study is the reluctance by health care personnel to accept the wishes of the patient if it is against their own professional judgment, that is, not quit smoking or giving biscuits to a patient with diabetes.

The study 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. They were sometimes unable to provide care at the standard they had preferred, and examples of the use of sedatives due to limited resources are also found in other studies (Yous et al., 2019). An intensified workload 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 (Suhonen et al., 2018). The authors support the idea that volunteers should be integrated into the care of older people, and volunteer programs are found to improve patients' health and well-being (Blais et al., 2017; Saunders et al., 2019). Nevertheless, there is a need for more qualified staff, and especially young nurses in this study wished for collegial supervision from more experienced health professionals when encountering challenging situations. This is in accordance with Haahr et al. (2019) that state that nurses' individual competencies are not enough to help them perform care according to their own ethical and moral standards; they face inhibiting factors through oorganizational structures, the work environment, political agendas, and more.

Strengths and Limitations

The relationship of the researcher and the participants should be described in qualitative studies (Tong et al., 2007). The authors believe that because the students were not aware of their possible participation during the writing of the assignment, they could write freely. This was chosen because if they had known about the research, that could have influenced their writing. The first author is a teacher and asked permission to use their notes, that could have been a "pressure" toward accepting. However, five students declined to participate, indicating they could freely choose. Although the first authors had prior knowledge about the content of the reflection notes, this is not considered a limitation because the other researchers had no affiliation to the students and the analysis of the written notes is a co-production between the three authors.

The authors discussed different points of view and reached an agreement about the themes and subthemes; this strengthens the credibility (Polit & Beck, 2012) of the analysis. Furthermore, regarding aspects of trustworthiness (Polit & Beck, 2012), the study portrays a variety of practice

situations and includes many narratives and text quotes to strengthen authenticity. In addition, two student participants read through the final report of the findings and gave written comments. These participants thought the findings were recognizable to their experience as gerontological nurses.

The number of reflection notes was found to be satisfactory, regarding both the breadth of themes and the commonalities found across the notes. Because of the notes being limited to 500–800 words, the number of notes was manageable for thematic analysis and the author's 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. Other researchers assert that the similarities of nursing globally, suggest that parts of qualitative findings can be transferable between health care settings (Tønnessen et al., 2016). Therefore, it is likely that countries with similar care services as Norway may find transferable knowledge.

Implications for Practice

This study provides new perspectives and knowledge about ethical challenges in older people nursing. The participants' experiences give insights into the struggle to perform professional care in institutional health care services. Nurses' position as clinical leaders puts them at the front in the management of ethical challenges, and they meet complex patient needs and maneuver scarce resources in their daily care. The participants' reflections also portray management of ethically challenging situations, indicating that high quality in care is possible despite scarce resources. Hopefully, these reflections on ethical challenges may contribute to encourage nurses to work in health care services for older people.

Conclusions

The study findings point to the fact nurses strive to "*do what is in the patients' best interest*", and this is fostered through collaboration, professionalism, care, and presence. Nurses' ethical decision-making may develop when reflecting upon their own care performance, therefore building ethical competence should be a priority in the education of health care professionals and in clinical practice. Awareness of ethical challenges and systematic ethics work should be supported by leaders and colleagues at the workplace. However, to improve care quality, there is also a need for sufficient qualified personnel with professional knowledge about older people nursing.

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ORCID iDs

Linda Rykkje https://orcid.org/0000-0001-6449-3615
Anne Lise Holm https://orcid.org/0000-0003-2043-8547

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