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A threat to our integrity – Meanings of providing nursing care for older patients with cognitive impairment in acute care settings

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A threat to our integrity – Meanings of providing nursing care for older patients with cognitive impairment in acute care settings

Background: Older people with cognitive impairment represent a large group of patients in acute care settings. Research show that these acute care environments can be unsafe and even unfriendly for frail older patients. Research and clinical experience show that being a nurse in acute/specialised medical facilities means to work in a high-speed, technologically complex and demanding environment. When caring for older patients with cognitive impairment, nurses' workload and responsibilities have been shown to increase. This is largely dependent on how easily it is to connect with and help patients understand what to do, and what is best for them.
Aim: This study aimed to illuminate meanings of caring for older patients with cognitive impairment in acute care settings as experienced by nursing staff.
Method: A purposeful sample of thirteen nurses experienced in caring for older people with cognitive impairment in acute care settings participated in the study. Narrative interviews were conducted during autumn 2012 and interpreted using a phenomenological hermeneutic method.
Findings: Caring for older, acutely ill cognitively impaired patients was found to be very complex. The meanings of caring for these older patients seemed to change depending on the nurses' perceptions of the patients and the gap between what they could do (real) and wanted to do (ideal) in providing care for them. The greater this gap was felt to be and the more care was perceived as meaningless, the more serious was the threat to nurses' personal-professional integrity which could be at risk, compromised or harmed.
Conclusion: The comprehensive understanding indicates that being a nurse and having to care for older patients in acute care settings means providing nursing care in an environment that does not support possibilities to protect and develop nurses' personal–professional integrity.

Keywords: acute care, cognitive impairment, integrity, meaning, nursing, older people, personal–professional, phenomenological hermeneutical.

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Introduction

Older people with cognitive impairment constitute a particularly vulnerable group of patients with extended care needs; however, their specific needs are often given lower priority in the busy setting of acute care (1). Nurses have described their workload and their struggle to provide an acceptable level of care for all their patients (2–4), and providing care for such older people in acute care settings increases the nurses' workload and responsibilities (2, 5, 6). Many care demands that are often difficult to meet have been found to impact nurses' work satisfaction (7, 8), and negative attitudes in acute care towards older cognitively impaired people have been identified when staff feel that their care is burdensome (9). Although hospitalisation of older patients with cognitive impairment is common (10, 11), the literature provides little insights into nurses' lived experiences of meanings of caring for these elderly patients in acute care environments; this qualitative study aimed to fill this knowledge gap.

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Background

Older people with cognitive impairment represent a large group of patients in acute care settings (12). Research

show that these care settings can be unsafe and unfriendly for frail older patients (2) and can lead to complications such as pressure sores, faecal and urinary incontinence, fall-related injuries (13), infections (14) and malnutrition (15). Research has also revealed that providing care for these older patients in acute care settings puts great demands on nurses (16–18), related to the unpredictable nature of care, workload, reprioritisations, organisational routines, nurse shortages and a nonadapted and unsafe environment for such patients (17, 19, 20). In addition, it is not uncommon for frail older patients to develop some degree of acute confusion/delirium when hospitalised, adding to the demands on staff (21, 22). Encountering patients who are confused has been described as encountering the unfamiliar, where the patients' actions and words are unforeseeable and cannot always be relied on. Nurses must then be on their guard, and use themselves as a tool in caring for the patient (23).

In complex care situations in acute care settings, it has been found that nurses set themselves very high standards in their interactions with patients, and that lack of time to provide the care they want to provide can cause frustration and stress (24). Research has shown that being unable to provide an acceptable level of care may cause them to have a bad conscience (25), feel they are not good nurses (26), compromise their moral integrity (27) and/or deadening their conscience (28) in order to survive in acute healthcare settings. A substantive theory by Nilsson et al. (29) proposed that the provision of high-quality, person-centred care of older people with cognitive impairment is difficult in settings where there is not a consensus about how to provide tailored care for this population; the organisation is disease-oriented and, efficiency-driven; and, where the environment is hectic and inflexible. These factors were described as contributing to staff falling behind to meet the needs of older people with cognitive impairment and to patient suffering, family exclusion and staff frustration. However, no studies have been found that illuminate what caring for older patients with cognitive impairment means for staff, and there is a need to further increase the understanding of the meanings of caring in these circumstances.

The study

Aim

The aim of the study was to illuminate the meanings of caring for older cognitively impaired people in acute care settings as experienced by the nursing staff.

Design

The study used phenomenological hermeneutical analysis to interpret the meanings of nurses' lived experiences of providing care for older people with cognitive impairment in hospital settings.

Context and participants

The study was conducted at a university teaching hospital in northern Sweden. Participating nurses were recruited from general medical, oncology and neurological clinics with high prevalence of older cognitively impaired patients. The three clinics had a traditional corridor layout with a central nurse's station and institution-style hospital design with a combination of single and multibed rooms (the oncology clinic had only single-bed rooms). Study recruitment targeted registered and assistant nurses and an equal number of nurses from the different clinics were strived for. Nurse unit managers assisted by informing the nurses about the study. Contact with nurses agreeing to participate was established, and time and place for the interviews were determined. This resulted in eight registered and five assistant nurses, in total 13, agreeing to participate in the study. This is a slightly higher number than the 6–10 participants usually included in phenomenological studies (30). Participants' ages ranged between 23 and 63 years, with an average of 17 years of work experience in nursing and 9 years in their current unit.

Data collection

To engage participants in telling their stories, narrative interviews (31) were conducted and later interpreted to grasp meanings of nurses' lived experiences of providing care for older cognitively impaired people in these units. Participating nurses were asked to narrate a situation when they provided care for an older person in the unit, and to further elaborate on experiences, feelings and reflections connected with the situation(s). The interviews were conducted by all three authors either in pairs or alone, in a secluded room within the units. All interviews were tape-recorded and lasted between 20 and 62 minutes (mean 34 minutes).

Ethical considerations

Before the interviews, all participants were informed of the study purpose, of the right to refuse to participate in the study and to withdraw consent to participate at any time without reprisal. Confidentiality was assured and informed consent was obtained verbally. The study was reviewed and approved by the regional ethics committee (Reg. No. 2012–302–32 M).

Data analysis

All interviews were collated into texts and subjected to phenomenological hermeneutical analysis (32). In this

method, interpretation entails a dialectic movement between parts of a text and its whole, between explaining and understanding, and between semantic and hermeneutic interpretations. The interpretative process starts with the articulation of a naïve interpretation of the text as a whole, followed by structural analyses of the text to discard or confirm the preliminary naive interpretation by providing empirical arguments for or against the interpretation(s) made. This dialectic process of interpretation culminates in a comprehensive interpretation, representing an explicit interpretation of the text. This phenomenological–hermeneutical method derives from Ricoeur's work (33) on interpretation as further conceptualised by Lindseth and Norberg (32).

Interpretation process and findings

The naïve interpretation, structural analyses and comprehensive interpretation are presented below. To increase readability, the interview excerpts were translated and pauses, falterings and repetitions were removed (31). In the results, names have been changed to preserve anonymity.

Findings

Naïve understanding

The meanings of caring for older cognitively impaired patients seemed to depend on the perception of the patients and on the gap between what nurses can do (real) and want to do (ideal) in caring for these patients. If these patients were considered calm, content and easily guided, then the gap between real and ideal care was described as small. However, if and when these patients manifested unmet needs and/or distressing behaviours that the nurses found hard to interpret and manage, the gap between real and ideal care increased, making it difficult for the nurses to provide good care and meet the needs of older patients, their other patients and themselves. Thus, our naïve understanding was that the greater the gap was experienced between real and ideal care – that is, the greater the conflict between what one wants to do and what one can actually achieve – the more the nurses' personal–professional integrity was challenged.

Structural analyses

The structural analyses were performed in three steps. Firstly, the content was analysed to gain a general view of the manifest substance of the text, that is the exact words and concepts used by the participants. This involved reading the text and identifying meaning units. A meaning unit could be a few words, a sentence or a whole paragraph relating to the same content. Second, all meaning units were condensed and coded in relation to the content addressed, resulting in the construction of subcategories which were finally sorted into five categories: *descriptions of patients and their behaviour*; *descriptions of consequences for nurses ability to care; descriptions of feelings; descriptions of consequences for nurses ability to work;* and *descriptions of nurse actions in striving for control.* Thirdly, by reflecting on and comparing subcategories and categories with how the older patients' behaviours were described by the nurses and how this related to the gap experienced between real and ideal care provision and its consequences for nurses, three themes were formulated: 'I cannot fully provide the care you are entitled to' – risking personal-professional integrity; 'I have to go against your will for your own good' – compromising personal–professional integrity; and 'I cannot understand why you are hitting me when I am trying to help you' – harming personal–professional integrity.

'I cannot fully provide the care you are entitled to' – risking personal–professional integrity. In relation to this theme, we identified a small gap between perceived real and ideal care. Nurses described the care they provided as acceptable, even if they were not fully convinced that they were providing 'good' care for these patients, making it difficult for them to see themselves as good nurses thus risking their personal–professional integrity. In this theme, cognitively impaired older patients were described as calm, sweet, cosy, harmless and manageable, and these labels were commonly related to patient behaviour. As the patients did not disturb the order in the unit, no negative feelings towards them were evoked or expressed.

To a large extent, nurses said that they could provide the care they wanted to provide to all patients they were responsible for. However, a small but significant gap appeared between what nurses actually did for these older patients and what they considered they ought to do (i.e. provide good care). For example, the calm, quiet patients were described as receiving less time than other patients as they did not demand much. It was not possible to collect and use personal information when caring for an older patient to the extent nurses wished. Ulla said that she often lacked information that could facilitate a more person-centred care:

> I would find it very useful to know their habits, like when do they want to brush their teeth. On what side of the bed do they want to sit? I mean these little things that could make things so much easier for us.

It was repeatedly stated that the busy and unsafe acute environment, the rapid pace and lack of staff knowledge and continuity were less than ideal and meaningful in

relation to what these patients needed. This was illustrated by Maria:

> …we have discussed if whether these patients should really be cared for here in our unit, whether we have the competence needed. It's just the feeling that you may not be helping them as you would want, because you don't have the knowledge, you don't know, and it is not our sort of work. There is not much time and the environment here is not the best.

Another example of the gap between real and ideal care was the mixed gender rooms in the units. Sara explained:

> We have mixed gender bays and if there is one lady with dementia, the only lady in that room, she can get very anxious about having men here, just because she is older and in her day it was not very common to share rooms with other men.

Thus, a lack of knowledge and continuity, a heavy workload and the medicalised physical environment surrounding the acute care nursing of these patients posed challenges associated with integrity for the nurses.

'I have to go against your will for your own good' – compromising personal–professional integrity. In relation to this theme, the gap between real and ideal care grew wider compared to the previous theme. Nurses felt that they were unable to give the 'good care' they wanted to and were thus compromising their personal–professional integrity. This theme contained descriptions of older cognitively impaired patients difficult for the nurses to deal with, as it was harder to guide and make these patients understand what was going on. Patients were perceived as being demanding, needing supervision, diversion and correction. Words used to describe patients in this theme were confused, reluctant and demanding, and the emotions evoked in caring for these patients were described as feeling inadequate, angry, stressed, frustrated and afraid that the patients could hurt themselves.

The interpretation of comprising personal–professional integrity was based on descriptions of older cognitively impaired patients as having a greater need for time and attention, while nurses felt 'eaten away' by having very limited possibilities to provide this. Ewe described:

> It is eating me away not getting the time and peace to be present; you know you are not doing a good job.

When these older patients were reluctant and needed to be persuaded to cooperate, for example in relation to taking medicines, showering and even remaining in the unit, it was described as time-consuming barriers to care provision. Such situations became even more challenging when nurses felt stressed due to lack of time and other patient's needs, forcing them to act against the older patients' will because of being rushed. Medical and acute conditions were prioritised and older patients' specific needs did not really count, as guidelines or routine approaches to care for these patients were lacking. Sophia described how neither she nor the organisation was prepared for the time-consuming interactions with these patients:

> I am not prepared for the way these patients interrupt my working day, and we need to find solutions to problems as they emerge, our practice is based on the assumption that patients remain calm and comply.

Furthermore, participating nurses were not entitled to bring in extra staff when older patients experienced distress, but rather that the nurses in the unit needed to resolve such problems. Extra staff were only allocated when there were extended medical needs, or risk of physical injury. The difficult balance between responsibility for these older patients and insufficient resources to provide safe, meaningful and dignified care was very challenging as responsibility for older patients' safety and welfare ultimately rested with the nurse. So, when older patients were experienced as unpredictable or at risk of harming themselves, nurses felt compelled to check up on them constantly, which fragmented their work and was described as very stressful and burdensome. In Laura's′ words:

> The worst nightmare would be to have an accident of fall with a resulting head trauma because you were unable to be there and look after the patient the way you should have…

Lacking specific knowledge of older people and their needs and not having access to person-centred information were described as contributing to widening the gap between real and ideal care, making nurses 'act without a map and compass'. Anna spoke about her feelings of inadequacy:

> You simply feel inadequate, I cannot, and I don't have the knowledge. You try everything and anything and nothing seems to work. It's like you improvise, make random long-shots, trying one thing after the other.

When nurses were unable to communicate meaningfully with a patient but still needed to complete their tasks, such as taking important blood samples, they felt obliged to use physical force, such as holding the patient's arm. The nurses described situations where continence pads needed to be changed or wounds dressed, while the older patient was protesting by screaming, pinching or spitting. The nurses felt they were almost committing assault when being forced to act against an

older patient's will and/or use tranquilisers to manage tasks, treatments and nursing care. As Karin said:

> She was very unpredictable and aggressive so you had to be very calm and prepared for a long haul, at the same time her nappy had to be changed frequently often involving washing her. She did not cooperate, and sometimes two people were needed, one who could hold her arms' so that the other could clean her up.

However, the text indicated that it was easier to act against a patient's will if it was evident that it was in the best interest of the patient. Such insights and beliefs seemed to generate less feelings of compromising of personal–professional integrity.

According to the text, caring for the fundamental needs of older cognitively impaired people was not perceived as explicitly part of the organisational discourse and planning within the clinics. Helen's description indicates a perceived low priority in the organisation regarding caring for these older patients:

> We have specialist groups for intoxication, heart care, hygiene care and probably a couple of more groups, but we do not have one for acute confusional states. We have debriefing after cardiac arrests, but never after this type of problem (confusion) even if these can be infinitely more demanding than a cardiac arrest.

'I cannot understand why you are hitting me when I am trying to help you' – harming personal–professional integrity. The texts in the third theme closely resemble those in theme two, except that the gap between real and ideal care appears unbridgeable in theme three. Traces of actual harm to personal–professional integrity surfaced. The descriptions of older cognitively impaired patients in this theme were similar to those in theme two, but the words in this theme were stronger and had more negative connotations, such as acting up, being frightening, crazy and being a threat. The emotions evoked by caring for these older patients included powerlessness, inadequacy, anger, frustration, stress, fear, being insulted, drained and losing control of one's own feelings. The interpretation that personal–professional integrity is harmed when there is an unbridgeable gap between real and ideal care was based on descriptions of experiencing the care provided as meaningless, being forced to act unprofessionally, and not daring to reflect on the care provided. Under these circumstances, it was difficult to feel that one was a good nurse. Older patients' needs outweighed other work obligations, and nurses felt forced to team up in order to handle the situations. When attacked verbally, sexually or physically by such patients, nurses described feeling attacked as a person and not as a nurse. Being afraid and uncomfortable with patient behaviours were challenges associated with integrity and as such difficult to bear. The quotation below exemplifies Lena's frustration when unable to care for a patient properly:

> You become so frustrated that you have to leave the room, it feels like you cannot cope with this, it is too difficult when you are pinched, hit or have your hair pulled. I have certainly walked out of showers and felt 'no way, someone else needs to take over.

Harming personal–professional integrity surfaced in relation to feelings of being personally offended, and not being able to act professionally. When patients intruded on nurses' personal space, it was described as the patient 'getting under your skin'. Ewe described:

> The question is how long I can put up with him invading my personal space. I mean I'm only human in that I become offended and upset with patients who hurt me physically or say hurtful things without reason. I become offended as a person.

Experiences of powerlessness combined with a need to act in order to resolve difficult situations were described as very stressful. Experiences of not being a good nurse were related to withdrawing from a yelling patient, or acting contrary one's professional knowledge by having to give tranquilisers to uncontrollable and aggressive patients despite knowing the consequential risk of falls, or by 'bribing' patients to comply. For example by tempting patients with diabetes by using sugar; persuading an alcoholic with the promise of beer; or lying to patients to make them comply. These actions were described as clashing with many nurses' ideals, as Helen's quote illustrates:

> . . .one of the things that I have learnt from medical science is that you do not hand a cinnamon bun to a patient with hyperglucose, but that's exactly what I still need to do as we have tried everything else. However, this is in conflict with everything you've learnt about being a nurse.

Descriptions of being forced to deaden one's conscience and by that harming personal–professional integrity also surfaced, for example by ignoring older patients' screams, and/or disregarding confused patients' constant calls for attention. Lucy said:

> Yes, it sounds horrible when patients lie screaming in their beds, but what are we supposed to do? We cannot do anything! He lies there screaming but the moment you walk into his room, he becomes quiet. And when he starts again you may not have the time to go there, but you know. . .

Lucy continued to explain that reflecting on her work situation and the care provided was not an option if she wanted to avoid burning out:

> You are so used to working at this pace like, having someone around who screams and someone who is anxious. You get so used to it that so you don't really think about how it affects you. I have not reflected on that. You adapt, because if I were to allow myself to be affected more than what I currently am, I would probably get burnt out.

Few mediating factors were related to this theme despite the absolute necessity of 'letting off steam' in the nurses' station, sharing one's frustrations and being confirmed by colleagues aware of the ordeal of caring for older cognitively impaired patients who were acting up and disrupting the order of the unit.

Discussion

Comprehensive understanding and reflection

The meanings of caring for older cognitively impaired patients in acute care settings became increasingly apparent through the dialectic comprehension of each phase of the analyses. These meanings are conceptualised in the comprehensive understanding as a gap between real and ideal care, the sense of doing good or harm to patients and being or not being a good nurse and these aspects are the bases from which the meanings of caring for these patients surfaced. The greater the gap was felt to be and the more the care was perceived as meaningless, the more serious was the threat to the nurses' personal–professional integrity and traces of a deadened conscience and a move towards burnout started to emerge.

Our naive understanding, that the greater the gap between real and ideal care was, the more nurses' personal–professional integrity was challenged, opened the way for structural analyses and a comprehensive understanding. It indicates that one fundamental meaning of caring for older cognitively impaired patients in acute care settings is providing nursing care in an environment that does not support possibilities to protect and develop nurses' personal–professional integrity.

According to Hardingham (27), a person with integrity is a whole person. In that sense there is a correspondence between their actions, values and beliefs. Professions share certain values, and the integrity of a profession is important in maintaining public confidence (34). Within the nursing profession, this is described as requiring nurses to practice in accordance with the standards and values of the nursing profession's Code of Ethics (35). That by fulfilling their professional role, consistently delivering quality nursing care to all patients entrusted to their care (36). The concept of integrity includes a person's dignity, which can be violated (37). But, it is also described as a moral concept which includes critical thinking, a stable character and principled behaviour (34). As a nurse, integrity is therefore both personal (personal integrity) and professional (professional integrity), and since personal and professional integrity are almost inextricably linked in the individual nurse, we use the concept of personal–professional integrity in this paper.

A variety of concepts of importance of personal–professional integrity have been used in healthcare research. Examples are stress of conscience, moral integrity, moral distress, professional commitment and burnout (38–41). Studies show that they are related to health professionals' experiences of not providing good care and not receiving help and support to avoid cynicism and to maintain sensitivity in the meeting with vulnerable patients (28, 42, 43). In other words, there seems to be at least a theoretical relationship between these concepts and patients suffering from care (44).

Fagerström (26) show how nurses' work situations in acute care settings can be understood as a dialectic struggle between 'being' or 'not being' a good nurse. At a theoretical level, all patients should receive high-quality nursing care related to their needs. However, the clinical reality is that nurses have to divide their time among all patients entrusted to their care, the operation of the unit as well as their own and their colleagues' needs. The findings from this study in addition to the study by Chambliss (42) support the description by Fagerström (26) that experiences of 'being' or 'not being' a good nurse are closely related to the gap experienced between the care nurses want to provide and what they can actually achieve. Furthermore, it has been highlighted that the inability to deliver high-quality nursing care to all patients reflects the nurses' inability to control their work situation, and thus becomes a threat to their personal–professional integrity, which may result in exhaustion and stress (36). Threats and harm to the nurses' integrity can also have consequences for patient care, as it has been shown to lead to omission of care, ignoring patients and 'rough' care (36). Or, as found by Fagerström (26), care becoming reduced to a series of tasks to be completed where individual patient needs are lost in a state of 'nonexistence' for nurses.

It has also been shown that if organisational obstacles hinder the pursuit of professional goals, negative emotions arise among nurses (43). This can force nurses to deaden their conscience to continue working in health care, potentially at the expense of their own identity as a good nurse, as irreconcilable demands and expectations may bring on 'stress of conscience', which in turn can lead to burnout (39). We also found traces of a deadened conscience and signs of burnout in these nurses' narratives. Other serious consequences are observed when nurses' personal–professional integrity is threatened, including cynicism (28, 39), burnout, nurses' turnover or leaving the profession (45–47).

Results from the present study imply that maintaining integrity is a personal and not an organisational responsibility. For example, the care provision for older patients was not perceived by the nurses to be part of the organisational discourse and planning within the clinics. However, Benner and Wrubel (48) described it insulting to talk about individual strategies for coping with untenable situations when problems emerge at the organisational level. Results from several studies support the need to a radical rethink of healthcare practices in order to protect the personal–professional integrity of healthcare professionals thereby ensuring humane care and patient integrity (49–51). Considering integrity of practice at a group level is paramount as patient care invariably involves teamwork (43). It appears that a general organisational effort is necessary to support nursing staff and others in acute care (26, 36, 48).

This study found that caring for older, acutely ill patients with cognitive impairment was very complex and supports previous descriptions that such care requires specific knowledge and/or support from geriatric or multidisciplinary teams (2, 12). Two recently published cross-sectional studies found positive correlations between a person-centred care environment and job satisfaction among staff (52, 53). This suggests that a person-centred care approach at both the structural and individual level, together with knowledge provision, supervision and ethical rounds may support nurses in providing nursing care in an environment that protects and develops their personal–professional integrity. Further research linking these concepts and their relationships appears warranted.

Methodological discussion

The analyses of interviews were based on a phenomenological hermeneutic approach, appropriate for illuminating meanings of experienced phenomena (32). Information provided about the research process and the way in which findings are described and presented in this article, form the basis for assessing the auditability and persuasiveness of the study. According to Ricoeur (33), it is always possible to argue for or against an interpretation, to confront interpretations and to mediate between them. He described validation as an argumentative endeavour, *that is* the author enters into and situates the findings in an ongoing discourse by publishing them. A study then gains credibility if and when the results are sufficiently trustworthy for other investigators to rely on in their own work. Thus, the rigour of this study can be only partly established here and now.

The interviews can be regarded as short for inclusion in a phenomenological hermeneutic study. However, the interviews contained rich but often short stories about situation when caring for elderly with cognitive impairment and probing questions were asked when needed to develop or clarify the nurses' narration.

Conclusion

This study showed that caring for older cognitively impaired patients in acute care settings means providing nursing care in an environment that does not support nurses' possibilities to protect and develop their personal–professional integrity. Thus, the results agree with earlier work that highlights a need to ensure that nurses are supported in providing dignified care in such circumstances, and that they are given opportunities to reflect on and discuss the care provided and how it impacts on their ethos of care and personal/professional integrity as well as on patient and family health and well-being.

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Author contributions

All authors have agreed on the final version and meet the criteria of contributions to conception and design, acquisition of data, analysis and interpretation of data as well as drafting the article.

Ethical approval

The study was performed in accordance with the Helsinki Declaration (31) and approved by the Regional Ethics Committee (Reg. No. 2012–302–32 M).

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