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Older Adults Living in Sheltered Housing's Experiences of Involvement in Pro Re Nata Decisions. A Narrative Positioning Analysis

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Marianne Kollerøs Nilsen[1], Bodil H. Blix[2], Hege Sletvold[1], and Rose Mari Olsen[1,3]

Abstract

Decisions regarding pro re nata medications might be challenging due to the complex nature of the practice. The aim of this study was to expand our understanding of the experiences of older people living in sheltered housings with regard to shared decision-making concerning pro re nata medications. In this study, we conducted in-depth interviews with residents living in Norwegian sheltered housings. The analysis was inductive, based on a narrative positioning analysis. Twelve residents were interviewed, and three narratives representing participants' variation are presented. People take different positions in shared decision-making of pro re nata medication, and they position themselves variously at different levels and situations. Prevailing master narratives affect the residents' positions in shared decision-making. Contrasts in older adults' experiences indicate that shared decision-making is not straightforward and is highly reliant on the context. Seemingly, they wish to be involved and not involved at the same time, a contradiction that healthcare providers need to consider.

Keywords

residential care, PRN medication, aged care, decision-making, narrative analysis, Norway

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Introduction and Background

Pro re nata medications (PRNM) are given as a response to symptoms that occur without the requirement for regular medication. Hence, the administration timing of PRNM is based on residents' requests and/or nurses' observations (Nilsen et al., 2020; Stokes et al., 2004). Nurses working in sheltered housing describe numerous human factors affecting their management of PRNM and that impact the residents' health and safety (Nilsen et al., 2020; Vaismoradi et al., 2020). Studies have demonstrated that nurses play a vital role in decision-making processes regarding PRNMs (Murray, 2017; Sulosaari et al., 2011). Decisions regarding PRNM might be challenging due to the complex nature of the procedure, the many influencing factors, the varying underlying health conditions and needs of the residents, and the variety in PRNM therapies (Nilsen et al., 2020; Stasinopoulos et al., 2018; Vaismoradi et al., 2020).

In Norway, residential care for older people is provided in institutions (nursing homes) and sheltered housing (assisted living) (Daatland et al., 2015). The target population is older adults (>67 years). The residents have a right to daily care in accordance with their needs, including medication administration, if necessary. According to Norwegian legal regulation, residents in sheltered housing live in their own independent home, bought or rented from the municipality, and home-based healthcare services are provided by home nursing. There are variations with respect to staff competence and the amount and level of care provided in Norwegian sheltered housings (Daatland et al., 2015; Helse-og

[1]Faculty of Nursing and Health Sciences, Nord University, Namsos, Norway
[2]Department of Health and Care Sciences, Faculty of Health Sciences, UiT The Arctic University of Norway, Tromso, Norway
[3]Centre for Care Research Mid-Norway, Nord University, Namsos, Norway

Corresponding Author:
Marianne Kollerøs Nilsen, Faculty for nursing and health science, Nord university, Post box 474, Namsos 7801, Norway.
Email: marianne.k.nilsen@nord.no

omsorgstjenesteloven [Health and Care Services Act], 2011). Primarily, registered nurses have overall responsibility for managing PRNMs and regular medications. The task of managing medications may, however, be delegated to other healthcare providers, such as nurse assistants (in this article the term nurse is used for both). The head of the unit is responsible for delegation of medication administration and for verifying that providers have the required competence (Forskrift om legemiddelhåndtering [Regulations on medication management], 2008). PRNMs and regular medications are prescribed on the residents' medication lists. Because there are no physicians allocated to the sheltered housings, residents are followed up by general practitioners (Forskrift for sykehjem m.v. [Regulations for nursing homes], 1988).

The right to self-determination is central in health ethics and a guiding principle regarding decision-making in medication management (World Health Organization, 2015), and making patients protagonists of their care is a priority (Graffigna & Barello, 2015). In the Norwegian welfare system, the discourse of user involvement has changed since the 1970s (Askheim et al., 2017). Furthermore, all Norwegian citizens have the right to receive information and be involved in the treatment of their health conditions (Pasient- og brukerrettighetsloven [Patient and User Rights Act], 1999). There are different levels of user involvement (Arnstein, 1969), and studies indicate that several models for shared decision-making focus on the healthcare providers rather than the healthcare services users (Aerts et al., 2019; Bomhof-Roordink et al., 2019; Murray, 2017).

Decision-making processes involving healthcare providers and patients have been described with three models; paternalism, consumerism and shared decision-making (Costanzo et al., 2019). Shared decision-making involves patients together with nurses in the decision-making process, where nurses should include the patient's preferences simultaneously to see a complete picture of the situation and judge the different choices within the room for maneuver (Costanzo et al., 2019; Gillespie & Peterson, 2009). Factors known to generate stress of conscience in residential care facilities for older adults include difficulties in redeeming all preferences, such as balancing priorities and following rules and recommendations (Ericson-Lidman et al., 2013). A qualitative study from Norway found that healthcare providers highlighted resident involvement when making decisions regarding PRNM, still they acted as gatekeepers (Nilsen et al., 2020). Some patient groups, particularly older people, are not familiar with shared decision-making (Elwyn et al., 2012), and the patients' health literacy is essential in understanding the information and consequence of choices (Elwyn et al., 2012; Pettersen & Jenum, 2014). A qualitative study found that residents in nursing homes, and to a certain extent in home-based care, are modest and grateful for the help they receive, but involvement in decision-making processes does not occur to any significant degree (Haukelien et al., 2011, p. 38). In a study of residents' involvement in decision-making regarding medications in Irish nursing homes, Hughes and Goldie (2009) found that the nurses and general practitioners and the residents recognized disempowerment and loss of autonomy in the care setting. The residents were passive and accepting of the decisions and seemed to be happy with the arrangement. Although the healthcare providers in the study wanted more resident involvement, such involvement could compromise the professional role and control of ensuring patient safety (Hughes & Goldie, 2009). Among the few reported studies about shared decision-making and PRNM from residential care facilities for older adults, the focus is on the healthcare providers' rather than the residents' needs (Aerts et al., 2019; Dörks et al., 2016). A literature review from mental health services, found that shared decision-making of PRNM is possible only if the patients are willing to become involved and have adequate knowledge about their medications (Hipp et al., 2018).

There are few recent studies about shared decision-making and PRNM. There is also limited knowledge of how older residents in residential care facilities experience PRNM decision-making. User experience positively affects clinical effectiveness and patient safety, and the inclusion of patient experience may highlight challenges in the quality of healthcare (Doyle et al., 2013). This study aimed to expand our understanding of residents' experiences of being involved in shared decision-making processes regarding PRNM. The following research question guided the study: How do older adults living in sheltered housing experience being involved in the shared decision-making processes of PRNM? How do they position themselves (and others?) in their stories about decision-making regarding PRNM?

Method

This study was conducted using a qualitative, explorative, and interpretative design. Data were generated through in-depth-interviews, which is a suitable approach when the aim is to obtain a deeper understanding of a particular phenomenon (Kvale & Brinkmann, 2009).

We used a narrative approach in which the participants' narrations are not considered as a mirror of the world, but rather as a social practice (Mishler, 1995), a process of meaning-making and co-construction between the participants and the interviewer in a given context (Bamberg, 2012; Riessman, 2008).

The authors' professional background varied, including two pharmacists with experiences from community pharmacies (Nilsen and Sletvold), and two registered nurses (Blix and Olsen) with clinical experience from nursing homes and home care services. All had many years of teaching experience from higher education and experience with qualitative research. However, none had clinical experiences from sheltered housings.

Recruitment and Participants

The study was conducted in four different municipalities in mid-Norway. We contacted head of unit in 10 sheltered housings by mail and telephone and asked for help to recruit residents. The inclusion criteria were residents receiving help with medication administration, who used at least one PRNM, and was able to participate in an interview (consent competent). We used analgesics and hypnotics as examples to facilitate the residents' understanding of the concept PRNMs. The total number of residents in each sheltered housing varied between 10 and 30. Five heads of unit recruited 12 residents.

The heads of unit distributed information letters and consent forms to residents fulfilling the inclusion criteria. The information letter specified that information from the interviews would not be available for the staff in the sheltered housings. Furthermore, head of unit facilitated for researcher to get in contact with residents. We have no knowledge about the head of units' judgements and how they approached the residents. A total of 12 residents agreed to attend an interview and signed the consent form before participation. The sample size was guided by the "information power" concept (Malterud, et al., 2016).

The participants were eight women and four men, 64–96 years old. The residents lived in four different municipalities and five different sheltered housings. The housing period in the actual sheltered housing varied between two months and 10 years. The participants used between one and 10 regular medications and between one and four PRNMs. Ten of the residents lived in housings with round-o-clock healthcare service.

Data Collection

All individual interviews were conducted by the first author from December 2019 to June 2020. A semi-structured interview-guide (Kvale & Brinkmann, 2009) guided the interviews. The opening question was, "If you should tell me something about your current medication use, what would you tell me?" Some participants spoke without solicitation, whereas others required probes to continue their stories. The follow-up questions varied, depending on the resident's response to the opening question. In collaboration with the participants, the researcher dynamically navigated the interview-guide. This flexibility is necessary because it is important to be open to the unexpected (Patton, 2015). A pilot interview with a home-dwelling woman (71 years old) was conducted to explore the understandability of the questions. This interview was not included in the data material.

The interviews lasted from 21 to 58 minutes. The interviews took place in the sheltered housing. In 10 of the interviews, only researcher and participant attended. In two interviews, a professional interpreter assisted using sign language because the participants had hearing impairments. The interviews were audio-recorded and transcribed verbatim.

Ethics

The Regional Committees for Medical and Health Research Ethics (REC) in Norway [reference number 32312/REK Nord] concluded the study was outside REC's remit and did not require approval. The study utilized sensitive personal information, and the Norwegian Centre for Research Data (NSD) approved the project [reference 480649]. The ethical principles of the Declaration of Helsinki were followed (World Medical Association, 2013). Participation was voluntary, and a written informed consent was required from each informant, and the participants could withdraw at any time. The participants were consent competent and information about the study was repeated orally before starting the interview. Confidentiality was maintained throughout the project. The audio recordings were deleted consecutively after transcription.

Using the head of unit for the recruitment of participants, may have led to an unspoken pressure to attend the interviews. At the outset of each interview, the interviewer stated the participant's right to withdraw from the study. We have no knowledge or influence of how the participants were selected beyond the inclusion criteria. The only feedback we received from the head of unit was that there were few candidates meeting the inclusion criteria.

Analysis

All interviews were transcribed verbatim. The interviews were analyzed using a narrative positioning approach (Bamberg, 1997; Riessman, 2008). This analysis focuses on how and why people tell their stories, to whom they are told, and what the story is about. Narration is seen as a meaning-making process where storytelling is a social construction between the researcher and participants (Riessman, 2008). Through our analysis, we explored how the participants positioned themselves in both the interview settings and in the stories they told and how the narrations were framed and shaped by various master narratives (Bamberg, 1997; Blix, 2017).

The analysis was stepwise, including, as a first step, a naive reading of all the 12 transcribed interviews to obtain an overview of the data. Next, we decided which interviews to include in the analysis. Choosing stories for focused attention is a crucial step in narrative analysis (Frank, 2012). For this study, three interviews were included. The analysis of the three interviews was informed by the insights gained from all 12 interviews. The remaining nine interviews provided contextual information about sheltered housings and PRNM decision-making in this context. Moreover, we gained insight in the diversity of the participants' experiences through the close reading of all interviews, which in turn guided our choice of interviews for further analysis. The three interviews were not chosen because we considered them as representative of the total interview material, but rather because of

their distinctness with regard to the phenomenon to be explored. The three included interviews represented variation with respect to both the participants' gender and age. Moreover, the three interviewees represented diversity with respect to their involvement in PRNM decision-making.

The three interviews were managed separately. The interview segments concerning PRNM and decision-making were identified through close and repeated readings of each of the transcripts. Next, we conducted a narrative positioning analysis (Bamberg, 1997) of the identified interview segments. Bamberg has suggested three questions to guide the three-level positioning analysis (Bamberg, 1997; Blix, 2017). At level 1, the analysis focuses on what the story is about and how the story characters are constructed (i.e., as protagonists and antagonist); "How are the characters positioned in relation to one another within the reported events?" At positioning level 2, the question is "How does the speaker position him- or herself to the audience?" This level concerns the story's *how*—why this particular story was told in this particular way under these particular circumstances. On level 3, the analysis focuses on how the narrator positions him or herself related to broader social or cultural discourses or master narratives in society. The question guiding the analysis is "How do narrators position themselves to themselves?" Eventually, we combined the analysis of the three individual interviews to explore different approaches to decision-making regarding PRNM. The analysis was performed by Nilsen, Blix and Olsen.

Results

In the following, we present sections from three interviews with residents living in sheltered housing: Anne, Maria, and Henry (pseudonyms), followed by the three-level positioning analysis.

Anne: It's Nice to Receive Help, but I Need my Sleeping Pills

Anne is a 94-year-old woman. She was raised on a farm where she had to participate in farm work already in her childhood, and she also lived and worked on a farm as a grown-up. Anne thinks that it is nice and safe to live in sheltered housing, and she cannot remember for how long she has lived here. Initially, Anne claims not to use any medicines, and medication is of no concern to her. However, throughout the interview, she talks about her daily heart medicines and the PRNM hypnotics and analgesics. She uses PRNM more or less on a regular basis:

> Of course, I use more (medications), but I am not interested, you see, so you are talking to the wrong person. It is a sleep medication, and it contains a pill helping me to fall asleep—a small one.

Despite Anne's statement that she is not interested in her medicines, her experiences show that, in particular, the hypnotics are important to her. One of her stories involves a nursing home physician who denied her using hypnotics:

> I was at the nursing home, and she (the physician) denied me (the hypnotics). I said I would try to endure—I will try to. Fourteen days passed. Then, I said stop, I am going crazy. "If I don't get the small pill, then it's impossible for me to stay here." Then I got one. (…) Now, I get one every evening. Imagination is important (laughs), I admit.

Although Anne questions whether a nursing home physician can make decisions about deprescription on behalf of the residents, she also talks about growing up in a decade when you were not supposed to demand anything, particularly from authorities such as physicians:

> During the war, when my appendix was removed, I didn't dare ask for necessary information—no way! I just sat still. He (the physician) looked so angry. Today, I would have said something to him!

Further into the interview, Anne states that she has used hypnotics for a long time. She relates about how a good night's sleep has been important to function during the daytime while she was working:

> I have used them (sleep medication) ever since I worked in a barn and stable; otherwise, I could not have worked. I experienced that it wasn't possible. Nowadays, nothing affects work here, but my body feels different.

For Anne, it is a relief not to have responsibility for her medication management because she does not trust herself and is afraid of making mistakes.

> A (Anne): I have to say I don't know (which medications she uses). I get some tablets, but it doesn't interest me what it is because I will not remember anyway.
>
> I (Interviewer): Do the personnel bring your tablets?
>
> A: Yes, they bring them all. I am not concerned with the medications—not at all—not even the name, size, or how many. They sort it out. It makes me feel very relieved.
>
> I: You find it comfortable?
>
> A: Oh yes, I do. I wouldn't have trusted myself if I had this responsibility.

At the same time, Anne experiences that the nurses trust her with the responsibility to self-administer the medications she takes before going to sleep:

I: When you talk about Paracet®(acetaminophen/paracetamol) and a sleeping pill being provided to you in a cup, do they (the nurses) bring it to you earlier in the evening, and then you take them yourself?

A: Yes, I do. Maybe they cannot do it this way for everyone—I don't know. I won't brag, but I think they must trust me not to mix (the tablets) when I get one of each: I get a small one for sleeping, and the other is Paracet®.

Henry: I have to supervise the Medication Management

Henry is a 64-year-old male resident who has lived in the sheltered housing for nearly 3 months. Sections of his life have been challenging, partly due to addiction to alcohol and drugs. As a grown-up, he worked at sea and as a chef. Henry has a good overview of his medications and what the different tablets are for, although he claims this is of no importance to him. He takes 10 tablets each morning and eight tablets each evening, and he uses analgesics and tranquilizers as PRNM. The hypnotics he used previously have now been replaced by an over-the-counter preparation.

Henry talks about adjustments in his PRNM:

I argued for my opinion. I must get what I have now; otherwise, I will be in too much pain. When I collapsed last spring, I didn't have Sobril® (oxazepam) or benzo-(benzodiazepine)—I didn't. I had like Atarax® (hydroxyzine) and other milder medications. Then, I always had malt beer available—it was my safety net.

Henry talks about his past as an alcoholic and being Stesolid (diazepam)®-addicted, and how he, through close collaboration with a specialized nurse, managed to overcome the addiction:

H (Henry): Some years ago, I was totally addicted to Stesolid®. Stesolid® and moonshine (homemade alcohol) is not a good combination. (…) with good help from a psychiatric nurse, with whom I am still in contact, I got out of this mess and was free from addiction. I had 25 Stesolid® a week (…)

I: Was this something you initiated?

H: No, but it was a collaboration.

Henry will avoid a relapse, and states that the medication made him someone he does not want to be:

Something important for you to include in your report or article involves the emotional aspects of life—that engages me! I have to say that yes, I am not totally without emotions now, but I am not laughing as much as I used to.

Medication management is not a burden to Henry, but he thinks it is perfectly fine to have these medications administered by someone else as long as he receives the correct medicines. He verifies the medications given to him:

H: I have received the incorrect medicine several times—you know. Then, I just rolled over (in his wheelchair to the nurses' office) and told them: "here, there is something wrong", and then I usually say something like, "If you, as a nurse, do not take care of it, then I will." I take what I am supposed to and nothing else, and if they bring me something else, which they did for a while, so fuck. I just said, "this is wrong—take it back!"

I: So you check the medications brought to you?

H: Yes, I certainly do!

(…)

H: I just take what I am given. But as I have said, I know what it (the medicine) is used for.

Henry talks about the future, and his ambition is to eventually drive a car again. The desire to gradually become more self-reliant helps him maintain his mood, and he hopes to be "himself" again and discontinue some of the PRNMs.

H: I have concluded that I need some extra Sobril® just now, but in the future, I think it is possible to adjust this medication. The Oxynorm® (oxycodone) as well.

I: You want to discontinue if you can?

H: Yes, if I can. When I am back on my feet and if the other medications' effects are good, I might ask for some gradual withdrawal just to try. (…) Of course, I must live with some pain—I don't want to be a "morphine-addict".

Maria: Medication Management is a Matter of Privacy

Maria is a woman, nearly 70 years of age, who has lived in the sheltered housing for 13 months. Previously, she lived in sheltered housing without round-the-clock nurses present. After a stroke several years ago, she is now wheelchair dependent, but she has no cognitive or verbal impairments. Throughout the interview, she is reluctant to discuss her use of medications and her life story. She thinks she uses nine medications, all administrated in the evening. Additionally, she uses a tranquilizer as PRNM:

I: Do you use other medications in addition to the regular ones?

M (Maria): (hesitating) It's the Sobril® then.

Even though Maria hesitates talking about using Sobril®, she explains the reason for using it:

I began with Sobril® because there was a fire in my previous housing. That experience stuck well in my body for a long time. I

never take Sobril® during the daytime—just one in the evening and one at night. That's all.

Maria prefers that nobody interferes with her medications—she wants self-control of her medication management:

M: I don't want to leave medication administration to someone else—I want to manage it myself. I have done so since the stroke.

I: Can you tell me something about the reason for this?

M: I think it is a matter of privacy

(…)

M: It was one (a nurse) who tried to take over my medication administration. "Forget it," I said, "I am fully capable of managing this on my own". (…) I don't think anyone should tell me what to use.

Maria contacts the nurses about her medication only when prescriptions must be renewed.

She has decided to take all her medications in the evening because she knows some of them make her lethargic, and she wants to avoid falling. Maria wishes to be informed about her medications:

M: I know it is a fall risk increasing medications. That's why I take them as the last thing before bedtime.

I: I understand you have some knowledge about your medications. Is this information something you have read, or has someone informed you?

M: I have internet.

I: Oh yes, you have internet (both laughs). So, you look it up?

M: Yes.

A Three-Level Positioning Analysis

The three narratives represent different approaches to PRNMs and decision-making. In the following text, the three positioning levels are presented separately, although these levels are interconnected.

Positioning of Characters in the Narratives

The three participants position themselves and other characters differently in their stories. However, they all talk about the decision-making process as involving themselves together with nurses, to a greater or lesser degree.

At positioning level 1, Anne positions herself as a protagonist in relation to the nurse in the story about the withdrawal of hypnotics in the nursing home (*"Fourteen days passed. Then, I said stop"*). She wants to do as the physician and the nurse decide and collaborate with them, but there is a limit. Even though she trusts the healthcare providers, they are not always in their right to decide everything. However, this aspect has changed from earlier times ("*I didn't dare ask for necessary information"*). The hypnotic tablets are crucial in Anne's story—they are important for her to function in everyday life, and she has used them for a long time. She positions herself as a passive decision-maker, as someone who has happily left the responsibility for her medications to the nurses, as long as they listen to what she says and respect her experiences.

Henry positions himself as an active decision-maker and the nurses as participants. He verifies the medications given to him, checks that it is the correct medicine (*"If you, as a nurse, do not take care of it, then I will"*). Henry says the nurses must accept his arguments, but he has also experienced how important the help from a nurse was for his recovery from the addiction to medications. Henry wants to have control over the decisions; however, he realizes that he needs some assistance. The PRNMs are important for him to cope with the situation, explaining why he wants to be an active participant in decision-making.

Maria positions herself as a leader and owner of the decisions regarding her medication. For Maria, medication is a matter of privacy and something she will control herself; nurses should not be involved unless she asks for it. She states a clear reason for initiating oxazepam use and is explicit about how she uses the medicine (*"I never take Sobril® during the daytime"*). She wants to be as independent as possible and decides when to contact the nurses regarding medications.

Positioning in the Interactive Setting

Positioning at level 2 concerns why a particular story is told to a specific person in a given context. The participants were well aware that the interviewer was a female, middle-aged pharmacist and a researcher conducting a study on PRNM decision-making.

At level 2, we identify a duality in Anne's narration. On the one hand, Anne positions herself as someone not particularly interested in medicines and "*the wrong person*" to be interviewed. On the other hand, as shown on level 1, Anne's stories demonstrate that the hypnotics have been significant for her for many years. She positions herself as a (self)critical user by referring to the power of "imagination." Anne emphasizes that the nurses trust her with the responsibility of administering her own medicine, but simultaneously, she makes it clear to the interviewer that she does not mean to "brag."

In contrast to Anne, Henry positions himself as someone who has important contributions to research. He is active in the conversation and finds it important that knowledge about the psychological consequences of medications is communicated. Moreover, Henry communicates that based on his life experiences, he has knowledge and insights the interviewer does not have. There is a duality in the way Henry, on the one

hand, positions himself as someone who "*just takes what I am given*," and on the other hand, as a person who is capable of confronting nurses when they give him the wrong medicines.

In contrast to both Anne and Henry, Maria is more reluctant to share her stories with the interviewer. She states that she considers medications a private matter. Nonetheless, throughout the interview, Maria positions herself as knowledgeable and perfectly capable of finding the information she needs.

Positioning with Reference to Cultural and Social Master Narratives

At level 3, we analyze Anne's, Henry's, and Maria's stories with reference to broader master narratives. In Anne's story, there is an undertone of a wish not to be a burden. This is evident in the way she gladly gives the nurses the responsibility for her medication and refrains from interfering with their decisions. In Maria's and Henry's stories, we identify a wish to be independent. For Maria, this is expressed in the way she takes full responsibility for her own medicines, whereas for Henry, this is expressed in his hope to get off medication and "back on his feet."

Generally in society, the ideal is restricted use of medicine. These discourses are also echoed in Anne's, Henry's, and Maria's stories; for example, in Henry's resistance against being a "*morphine-addict*" and in Anne's and Maria's choice of words. Anne defends her use of medicine and describes the tablets as "*small*," and Maria is careful when mentioning her tranquilizers. The PRNMs referred to are medications often associated with stigma and abuse potential.

Discussion

In this study, using a narrative positioning analysis, we show a variation in how people see themselves as a part of decision-making regarding PRNMs. Also, residents in sheltered housings position themselves differently in various settings.

Compared to other studies stating there is no equal partnership between nurses and patients in shared decisions regarding PRNM (Aerts et al., 2019; Hipp et al., 2018), this study shows that there are different partnerships, depending on how people position themselves and others. The analysis on level 1 and 2 illustrates how the three participants position themselves differently as decision-makers: Anne is satisfied being less active unless it is absolutely necessary to intervene, Henry takes a role as controller, and Maria wants to be the only decision-maker. From the stories told, there is apparently room for the different positions in the decision-making process in the sheltered housing. However, there could be unspoken tensions between nurses and residents if the residents had differing opinions about the treatment and care (e.g., Maria, who stated that nurses would take over medication administration). Shared decision-making implies nurses (and physicians) working together with patients (residents) to find the best solution, and the residents should be conscious users of healthcare services (Costanzo et al., 2019; Haukelien et al., 2011). However, shared decision-making relies on the residents' will (Hipp et al., 2018) and capacity (Elwyn et al., 2012; Pettersen & Jenum, 2014) to participate. Therefore, nurses must carefully tailor the decision-making process to each individual resident and fully explore the resident's needs, preferences, and wishes for care and treatment, as Vaismoradi et al. have also highlighted (Vaismoradi et al., 2020). The ideal about shared decision-making in healthcare highlights patients' right to be involved in discussions and decisions. However, the level of participation in the decision-making process can vary. A standardized way of making decisions, without considering the residents as participants, could lead to poor decisions that are not compatible with a holistic approach (Costanzo et al., 2019).

Furthermore, based on level 3 in the analysis, this study indicates that master narratives affect the experience of shared decision-making regarding PRNM. When making decisions together, the process does not take place in a vacuum (Askheim et al., 2017; Costanzo et al., 2019). In this study, the participants' ages differed by 28 years, which represents a generation. Anne was brought up in the interwar period, when patients in general and women in particular were expected to be less demanding, and user involvement in healthcare was not emphasized. Henry and Maria belong to another generation, which may be why they take a more active position. Residents in sheltered housing represent a heterogenous group of people. They all have individual life stories that affect their needs, preferences of medications, and meaning of involvement in decision-making. Knowing the residents is a prerequisite to succeed with user involvement (Ree et al., 2020).

The PRNMs mentioned by the participants appear to be important for their quality of life. The extent to which they are engaged in their medicine management differs between the participants in this study. The attention to reducing the use of medications may affect those in need of them. There is a focus on reducing the use of PRNMs such as benzodiazepines among older adults (American Geriatrics Society, 2015; O'Mahony et al., 2014). Perhaps this focus makes it difficult for people to state their actual needs for a PRNM without feeling like a drug-abuser. Hence, people receiving help with PRNMs might not express their needs for medicine. Anne has used hypnotics for years; however, in her older age, she almost apologizes for using them and blames "*imagination*." Thereby, she is dependent on nurses trusting and believing in her. Henry's and Maria's stories are also characterized by the kind of medications, which they supposedly should not use. Seemingly, Henry and Maria are safer in their decisions when someone questions the use. For all three participants in this study, safety and security are linked to receiving the PRNMs when they need them. This may be in conflict with the nurses'

professional view of what is the correct use of medications, as shown in another study (Ericson-Lidman et al., 2013). There must be a balance between healthcare provider control and user involvement (Hughes & Goldie, 2009).

When attempting to maintain patient safety, for example, through medication review, the resident must be heard. The participants in this study experience real needs, even if they cannot always explain why (as Anne). If residents are capable and willing to participate in shared decision-making, the involvement in medication reviews could help residents and nurses reach a common understanding of why PRNM are used and required in a certain way. Studies have demonstrated that being involved in medication reviews is regarded as mostly positive from the patient's point of view (Uhl et al., 2018), but the patient's involvement is often limited to information sharing (Willeboordse et al., 2014).

This study demonstrates a variety in residents' preferences, which underlines the complexity of decision-making. The analysis highlights different perspectives, ability, and will to be actively involved in decision-making. Storytelling is meaning-making (Bamberg, 1997), which makes it a valuable source for understanding a practice involving PRNM and decision-making, in a context which we have limited knowledge. Our results show how patient experiences can differ and provide new knowledge about how practice is co-constructed by the persons involved.

Strengths and Limitations

This study provides novel insights into the PRNM management process in sheltered housing. Few studies have explored residents' experiences of being involved in shared decision-making regarding medications, and thus, our findings may be important to safeguard patient safety and improve the quality of healthcare services (Doyle et al., 2013).

Using the narrative position analysis, we have showed contrasting experiences. By providing comprehensive descriptions of the participants, study method, and quotes from the interviews, we enable each individual reader to judge the transferability of the study findings to other contexts.

The focus of this study was medication management of PRNM. However, we believe that the findings can be related to decision-making regarding medication management in general. Although the study context is limited to sheltered housing, the findings are relevant for nurses in different types of healthcare services as well as in an educational context.

The fact that none of the authors had clinical experience from sheltered housings could be both a strength and a limitation. Lack of knowledge and personal experience about the context may have limited our understanding of the practice, negatively affecting comprehension and awareness of participants' expectations of decision-making processes regarding PRNM. In contrast, not having clinical experience from sheltered housings might be a strength since the researchers were not biased by contextual factors during the analysis. The participants talked willingly and openly during the interviews, seemingly comfortable with talking with an interviewer with the time and interest to listen. Thereby, the participant-researcher relationship might have benefitted from the researchers being unaffiliated with the sheltered housings.

For trustworthiness, researcher triangulation was performed, researchers with different experiences and backgrounds were involved in the analyses and writing of the article.

Conclusion

This study shows that older adults living in sheltered housing experience the shared decision-making process regarding PRNM in various ways. They position themselves according to different life experiences, which influence their role in the decision-making process. Our results highlight and expand the knowledge of PRNM decision-making processes as complex and multi-faceted, and as highly reliant on the context. Moreover, our results demonstrate the interdependence between nurses and residents in PRNM decision-making processes. The residents want to be involved and not involved at the same time and to various degrees. Taking these variations into consideration, nurses should provide dedicated attention to each resident's wishes and needs in the decision-making process, asking questions to ensure his or her understanding of PRNM and fully explore preferences of involvement in decision-making. Using arenas for encouragement and establishment of shared decision-making is advocated, for example, medication reviews including the patients. User involvement within medication management should be highlighted in nurse education.

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ORCID iDs

Marianne Kollerøs Nilsen https://orcid.org/0000-0002-6824-8550
Bodil H. Blix https://orcid.org/0000-0002-1049-4636
Rose Mari Olsen https://orcid.org/0000-0002-7009-8803

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Author Biographies

Marianne Kollerøs Nilsen is a doctoral student in the study of professional praxis at Nord university.

Bodil H. Blix is Professor in the Department of health and care sciences, Faculty of health sciences, at UiT The arctic university of Norway.

Hege Sletvold is an Associate Professor at Nord University, Faculty of Nursing and Health Sciences.

Rose Mari Olsen is an Associate Professor at Nord University, Faculty of Nursing and Health Sciences, Centre for Care Research Mid-Norway, Namsos, Norway.