

## **Carers' and nurses' appraisals of needs of nursing home placement for frail older in Norway.**

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## **ABSTRACT**

**Aims and objectives.** The aim of this paper was to explore carers' and nurses' appraisals concerning if and when nursing home placement for frail older awaiting placement was needed, and to illuminate ethical issues involved in decisions regarding nursing home placement.

**Background.** Requesting nursing home placement can be a complicated decision for carers, causing feelings of failure, anxiety, and guilt. After the necessity of nursing home care is determined, the names of the older are put on waiting lists. While waiting, home health care provides support services. Even with this care, many of the older and their carers face difficult life situations.

**Design and methods.** The convenience sample (n=36) comprised 11 carers of older people on a nursing home placement waiting list in Norway and 11 nurses caring for these older. All willingly participated in interviews that were transcribed and analysed by qualitative content analysis.

**Findings.** Various similarities and differences between nurses' and carers' appraisals were found. Complex ethical issues of justice, equality, autonomy, beneficence, and justifiability in nursing were involved in decision-making concerning nursing home placement. Four categories constructed were: 'appraising nursing home to be the level of care needed', 'appraising the older as able to continue living at home', 'being ambivalent about nursing home placement' and 'being sceptical about use of coercion regarding nursing home placement'.

**Conclusions.** Not all of the older awaiting nursing home placements could be placed in nursing homes when beds became available. The situations were complex and involved ethical issues.

**Relevance to clinical practice.** In spite of insufficient resources in home health care, providing appropriate support for the older and their carers means that nurses have to consider the individual concerns in each situation, co-operate with carers, respect their appraisals of needs, and argue for the timely nursing home placement of the older.

## **Carers' and nurses' appraisals of needs of nursing home placement for frail older in Norway.**

### **Introduction**

Carers of the older risk negative health outcomes, such as depression (Sherwood *et al.* 2005) and precipitated mortality (Schulz & Beach 1999), and have difficulty deciding upon nursing home (NH) placement in the US (Penrod & Dellasega 2001, Schur & Whitlatch 2003). Irish carers were found to often postpone NH placement until they no longer saw an alternative, resulting in feelings of failure, anxiety, and guilt (Ryan & Scullion 2000). When Dutch carers decided to request NH placement, some found it intolerable to face a waiting list and to perhaps wait several years (Meiland *et al.* 2001); Canadian carers had to wait up to 5 years for NH placement (Reuss *et al.* 2005). Many factors predict NH placement of the frail older, including cognitive impairment (Gaugler *et al.* 2007), altered mobility, and urinary and fecal incontinence (Buhr *et al.* 2006).

Carers stated various reasons for postponing NH placement; including fearing loneliness after placement and being insecure about NH quality of care (Hagen 2001). Older living in NHs in England received poorer care than those living at home, with respect to medication management and monitoring chronic diseases (Fahey *et al.* 2003). Some carers in the US refused community health services, respite care, or NH placement, even when they were in great need of it, in order to maintain their relationship with the older (Caron & Bowers 2003). In some cases, the older refused help as well. The most frequently mentioned reason for US carers not using community services was older resistance (Winslow 2003). Although many older Hong Kong Chinese had never visited a NH, they did not want to move into one (Tse 2007). Linzer (2002) discussed the ethical dilemmas involved with the older refusing NH placement as a conflict between respecting older autonomy and acting beneficently for older welfare.

During the waiting period, attitudes about NH placement of the older and carers can change. A majority of beginning Canadian carers favoured home care as 'best' meeting the older's needs, but over an 18-month period, many favoured NH care over home care. This reflected carers' difficulty coping with the older's increasing physical and cognitive dependency (Armstrong-Esther *et al.* 2005). It is probable that some carers who placed the older on

waiting lists changed their attitudes because of new coping measures, more adequate home health services, or improvement in the older's behaviour, for example, during more calm stages of advanced dementia disease (ADD). Other carers might place the older on waiting lists in the event that more urgent care needs arise.

Norway is facing an ageing population (Statistics Norway 2005). The national policy is to support older home care for as long as possible. This reduces national health care expenditures but poses great demands on informal care (Ministry of Health & Social Affairs 2002). When NH beds are unavailable, physicians and home health care leaders prioritize waiting list names based on a comprehensive assessment. Home care is government supported, but the older pay 75-85% of their income for NH care (Ministry of Health & Care Services 1995). This can be an economic burden for families. Norwegian municipalities have a juridical duty to offer respite care (the maximum price in 2008 was 12 GBP per 24 hours) to families providing particularly burdensome care (Ministry of Health & Care Services 1991). The Norwegian Board of Health (2003) has recommended using 15% of NH beds for respite care in order to adequately support carers. Still, in 2005, many Norwegian municipalities lacked respite care beds (Otterstad & Tønseth 2007).

In Norway, NHs primarily care for the frail older, about 80% of whom suffer cognitive impairment (Nygaard 2002). The media in Norway has often reported on unqualified personnel and unworthy conditions in NHs (Mersland 2005). One study, however, showed that most residents in a Norwegian NH received good basic care, but leisure activities, such as going for a walk, were often neglected (Kirkevold & Engedal 2006). In 1999, the majority of the Norwegian older preferred living at home with adequate home care (Otterstad 1999). According to Norwegian laws, the older who are competent enough to give informed consent have the right to refuse home health care or NH placement, and if incompetent, their next of kin acting in their best interest may consent (Ministry of Health & Care Services 1999a).

According to the Ministry of Health & Care Services (2000), NH placement should be based on the most urgent needs. However, since carers or the older can appeal NH assignment decisions to the County Governor (Ministry of Health & Social Affairs 1993), it is possible that this rule is not always followed. For example, 10 of 16 appealers were offered NH placement in 2004 in one county (County Governor in Hedmark 2005). Illuminating nurses'

and carers' appraisals of the older's needs for NH placement may contribute to broader understandings of ethical issues involved in deciding NH placement.

### **Aims**

The aim of this study was to explore carers' and nurses' appraisals concerning if and when NH placement for the frail older awaiting placement was needed, and to illuminate ethical issues involved in deciding upon NH placement.

### **Method**

#### **Sample/Participants**

This study was conducted in a small municipality in Norway. Criteria for participation were acting as a carer or nurse providing care to older on waiting lists for NH care and the ability to communicate in Norwegian. For breadth and diversity in data, we selected a convenience sample comprising 11 carers with different kinship to the older (three men, eight women; 71-99 years (Md=88); six with ADD and five with various physical diagnoses; seven living alone) and varying degrees of workload from a sample (n=36) previously described (Fjelltun *et al.* 2008). All carers, i.e., three wives aged 70-79, three sons aged 60-62, and five daughters aged 44-72, consented to participate. All except four were employed in addition to caregiving. Eleven nurses (two men) providing care to the same older as the participating carers also consented to participate. They had been employed in home care 1-17 years (Md=5). Seven were registered nurses (RNs), two of whom were specialized in elderly care. Four were enrolled nurses (ENs) (Table 1). In this paper the term 'nurses' refers to RNs and ENs when not otherwise stated.

Please, insert Table 1

#### **Data collection**

Between September and November of 2005, carers and nurses were individually interviewed. Carers were asked to narrate their experiences with elderly care, daily routines, health services, what they learned, their thoughts about the future, and whether or not they would accept a NH placement offer. Nurses were interviewed about their experiences caring for this older, focusing on need and amount of care given, NH placement, and collaboration with

carers. Interview guides were used. Each interview (n=22) lasted 50-60 minutes, was audio-recorded, and then transcribed verbatim, noting emotional reactions.

### **Data analysis**

The interviews (about 110,000 words) were analysed by qualitative content analysis. Interviews of carers and nurses providing care to the same older were analysed in pairs. Each interview was read and divided into meaning units that were condensed, labelled with a code, compared, abstracted and clustered into 11 sub-categories grouped into four categories. To compare paired interviews, the sub-categories were placed in 11 two-columned tables with carers' and nurses' appraisals side-by-side. By reflecting on ethical issues involved in the sub-categories, five themes were constructed. To address trustworthiness, co-authors who were experienced in elderly research and the research method checked and discussed analysis and interpretations to reach consensus (Graneheim & Lundman 2004). The categories, sub-categories, and themes are shown in Figures 1-2.

Please, insert Figures 1-2

### **Ethical considerations**

The study was approved by the Head of the Social Welfare Unit at the municipality and the National Committees for Research Ethics in Norway (57/2004).

The participants were invited to participate by the head nurse in their home service areas. They were assured confidentiality, guaranteed participation was voluntary, and informed they had the right to withdraw at any time without stating a reason. Before data collection began, written informed consent was obtained.

### **Findings**

The situations for carers and older awaiting NH placement were complex, and the need of NH placement varied. Complex ethical issues of justice, equality, autonomy, beneficence, and justifiability in nursing were involved in decision-making concerning NH placement.

## Themes

As most categories involved some ethical issues, these will be reported within each category. The five themes were labelled 'ethical issues concerning justice', 'ethical issues concerning equality', 'ethical issues concerning autonomy', 'ethical issues concerning beneficence', and 'ethical issues concerning justifiability in nursing'.

## Categories

The four categories were labelled 'appraising NH to be the level of care needed', 'appraising the older as able to continue living at home', 'being ambivalent about NH placement', and 'being sceptical about use of coercion regarding NH placement'. The categories are presented with sub-categories and quotations.

### *'Appraising NH to be the level of care needed'*

The category 'appraising NH to be the level of care needed' had four sub-categories. In this category carers and nurses together agreed and presented reasons for urgent NH placement. In addition, this category reflected carers' situations as indicated below, appealing the waiting time, and nurses' frustrations.

### *'Presenting reasons for urgent NH placement'*

Carers and nurses agreed that NH placement was urgent. One reason was the low quality of the older's lives, such as poor hygiene and inadequate nutrition. This raises ethical issues of justifiability in nursing. Some older had ADD, lived alone and were often afraid. One daughter narrated: *'She is sitting there lonely, hallucinating, and afraid of everyone she believes locks themselves into her flat to shower and eat'*. Some older were awake at night, engaging in seemingly purposeless activities, and some refused help from nurses. Both carers and nurses worried that something dangerous, like starting a fire, would happen. One woman would wander outside, unable to find her way home. All nurses agreed that these older would have a much better quality of life in NHs. In addition, carers feared that when NH placement finally happened, the older would be too ill to find it pleasant. One son, fearing his mother would soon become bedridden, hoped she could move to a NH while she could still be active and get to know other residents. The RN confirmed his worries: *'If she has to wait too long, and gets worse, she will soon become bedridden'*.

### ‘Indicating carers’ situations’

Carers had personal health problems, such as heart disease, back pain, headache, and disturbed sleep, and some were very exhausted and isolated from providing 24-hour care. Nurses, aware of carers’ exhaustion, worried about them. One RN said: *‘The older remain at home as long as possible, to the border of what their carers can handle and cope with. Carers are, in a way, exploited, stretched until the end’*.

### ‘Appealing’

Relatively young carers, knowledgeable about NH placement regulations, had recently appealed the waiting time, resulting in placement offers within days. These carers were relieved and looked forward to placement. In these cases, nurses were content as well. An RN, however, confirmed that assignments of NH placement could be random and not strictly based on the older’s needs, but instead could be a reflection of carers’ resources for appealing, which raises ethical issues of justice. An EN said: *‘If we had enough NH beds, I could accept it, but other older are lying in bed all day. Sometimes ‘completely healthy’ people are prioritized. I wonder why, when we can have 10 older who need it more’*. Another arena for complaining was the media. One daughter considered contacting the media before she successfully appealed. She refrained from doing so because she felt it was an ethical dilemma, especially since her mother with ADD was unable to consent.

### ‘Describing nurses’ frustrations’

Nurses were frustrated because the shortage of NH beds caused long waiting periods for older. Simultaneously, home health care did not have sufficient resources to satisfactorily support the older and their carers. One RN was frustrated because she had insufficient time for training an old woman. She said: *‘All her care needs take so much time that we are not able to train with her. I cannot wait, so I take over. It is paradoxical; nurses are doing all tasks for her, and simultaneously requesting a rehabilitation stay’*. This raises ethical issues of justifiability in nursing. Some nurses worried about the older during their leisure time. An RN considered finding another job: *‘It seems much easier, to work in a hospital surgical ward; to be able to leave and know the patients are cared for’*.

### ‘Appraising the older as able to continue living at home’

The category ‘appraising the older as able to continue living at home’ had two sub-categories. In one sub-category, carers tried to keep older at home for as long as possible because of love,



companionship, and duty. In another sub-category, nurses appraised the older not needing NH placement.

‘Experiencing love, companionship, and duty’

Carers, mostly spouses, rejected NH placement because they wanted to keep the older at home. One wife could not accept NH placement although she knew she eventually would surrender because of her impaired health and exhaustion and her husband’s post-stroke hemiplegic and cognitive impairment. She narrated: *‘As long as I can manage, I want him to be home.... We have been married for almost 50 years, and we have had a very good life’*. Some older received NH respite care every two weeks, which, according to their carers, was important to their continued caregiving. Carers considered it their duty to maintain the older at home as long as possible. Nurses tried to support carers, promising that these older would be prioritized for NH placement when requested by carers, especially those who were already offered placement.

‘Not needing NH placement according to nurses’

Carers wanted NH placement, while nurses appraised the situation satisfactory, even though a physician and home health care leader had previously decided NH to be the needed level of care. One older woman living alone suffered from urinary and faecal incontinence and had a tendency for falling, but was functioning well mentally. Her daughter pushed NH placement, thinking her mother was depressed, lonely, and fearing she could fall and remain on the floor. The RN disagreed: *‘It seems to me she feels comfortable and safe at home. Often carers have one expectation while older have another’*. The daughter of a woman who was forgetful, and called her daughter several times during the night, was in despair because she had to work in the morning. In addition, she feared her mother forgot to take cardiac medicine. The RN considered the situation acceptable. She said: *‘Temporarily, the situation is safe. I know she has become more forgetful, but we follow her development. Still, she is relatively well functioning according to our standards’*. Differing appraisals of the older’s needs raise ethical issues of equality. Carers worried about the future and how they would be able to cope if they became more exhausted, and if the older became frailer while NH placement was still not offered. One daughter clearly knew when she would give up care: *‘When she cannot stand in the shower anymore, I give up. If no offer comes then, I will drive her to city hall, leave, and let the mayor take care of her’*.

*'Being ambivalent about NH placement'*

The category 'being ambivalent about NH placement' had two sub-categories. Carers were ambivalent about NH placement because they were concerned about NH conditions and economic consequences of NH placement.

*'Concerning about NH conditions'*

Carers with negative experiences about quality of NH respite care resisted NH placement. If the older they cared was psychologically well functioning, they feared it could be depressing to be with residents with ADD who were uncommunicative. One carer said: *'I am ambivalent about it. If she had NH placement, I would feel much safer. But I really do not know if I want her to sit there...'*

*'Economic consequences'*

One exhausted wife in poor health was ambivalent about NH placement. If her husband was placed in a NH, she would lose his retirement pension, become unable to pay rent, and perhaps lose her home. The RN confirmed that this older needed NH placement; he would quickly be admitted upon his wife's request. The RN wanted to respect and support the wife's decision, but felt this was an ethical issue about prioritising carer's needs over the older's needs. This raises ethical issues of justifiability.

*'Being sceptical about use of coercion regarding NH placement'*

The category 'being sceptical about use of coercion regarding NH placement' had three sub-categories. If placing the older in NHs involved use of coercion, most carers refused NH placement, although one son accepted the offer regardless. Nurses sometimes used persuasion and threats to influence the older's cooperation.

*'Refusing NH placement'*

Some older refused help from nurses, resulting in low quality and unjustifiable situations. An RN narrated: *'We have only been able to give her one shower during the last year... She always rejects our offer, saying she has already done it. We cannot use coercion. I find it very difficult'*. Still, carers of physically well functioning older found it heart-rending to place the older in NHs against their will. Some older lived alone; others with carers. One woman had said all her life that she would never move to a NH. Now, having ADD, she was mostly

uncommunicative and incontinent of urine and faeces. In spite of this, she had a crystal clear opinion about NH placement. Her son narrated his attempts to persuade his mother to accept NH respite care, which could become permanent. He commented: *'She definitely understood what I said. She shouted 'no' over and over with increasing volume, and a look in her face expressed 'over my dead body', totally terrified. We would have had to move her by force, so we refused. It is a hopeless situation'*. This woman's EN clearly stated that nurses could not move the older by force: *'We cannot use coercion. We do not have any legal basis for using it'*. These situations raise ethical issues of justifiability, autonomy, and beneficence.

#### 'Persuasion and threats'

While carers maintained that use of force would be necessary for implementing NH placement, nurses had another opinion. In the nurses' experiences, the older usually accepted NH placement after nurses spent time persuading them. Yet, a RN said that nurses could exploit the older's fear of NH placement by threatening to make them cooperate: *'Sometimes nurses use verbal threats, like 'If you do not cooperate; you will have to move into a NH'. Actually, I find this unethical'*. This raises ethical issues of justifiability.

#### 'Accepting an offer regardless'

One carer worried about telling his mother about an offer of NH placement because he knew she would refuse it. He was sceptical about the use of coercion, but said that he and his mother had to accept the offer regardless. He said: *'When we get an offer of NH placement, we cannot refuse it. Although she has always told us she will die before moving to a NH, she will just have to accept it'*.

## **Discussion**

The most important finding in this study was that many older people awaiting NH placement could not be placed in NHs even if beds became available. Many carers refused NH placement for various reasons. The urgency for NH placement varied, and deciding NH placement involved several ethical issues.

#### *Different appraisals of the same situation*

For some older, carers' and nurses' appraisals differed; while carers wanted NH placement immediately, nurses appraised the situation satisfactory according to their standards. For these older, it seemed like carers and nurses had different standards. Nurses emphasized the older's

own wishes and safety, as distinct from carers who hoped the older, especially those with ADD, could be placed in a NH, while they were still able to become comfortable and familiar with other residents. Other important conditions for carers included whether older maintained a minimal quality of life concerning safety, nutrition, and hygiene. Older people living at home can be at risk for malnutrition, which was the case for half of all older receiving home care described in a Finnish study (Soini et al. 2006). The nutritional status among the home-dwelling older in Norway has not been investigated, but many older were undernourished on hospital admission (Ministry of Health & Social Affairs 2006). Nurses, too, were concerned about the older's quality of life, and most nurses expressed frustration over NH bed shortages. Notwithstanding, nurses appraised some older as too high functioning for NH placement, in contrast with the physician and home health care leader who had previously decided NH to be the right level of care. This might be due to inaccurate appraisals or these older's frailty at the assessment time compared with the interview time. It may be that after placement on waiting lists, nurses had visited them more frequently and addressed their needs, thus resulting in increased physical functioning. Inaccurate appraisals raise ethical issues of equality. A study in five Norwegian municipalities showed a lack of clearly written criteria for assigning NH placement, resulting in some accidental assignments (Dale 1999). For most older with ADD, carers and nurses agreed about the need for NH placement. Similarly, a meta-analysis of Gaugler et al. (2007) found cognitive impairment to be a strong predictor of NH admission.

### *Appealing*

A general principle is that NH placement shall be based on the most urgent needs (Ministry of Health & Care Services 2000). The possibility of appealing assignment decisions to the County Governor (Ministry of Health & Social Affairs 1993) is one reason this principle is not always followed. Some carers successfully appealed the waiting time for NH placement. Yet, since appealing requires knowledge and resources, the idea of appealing is ethically problematic. This raises ethical issues of justice. It seems unfair that the older with knowledgeable and resourceful relatives have greater chances for NH placement than older with relatives who have less knowledge or fewer resources. In addition, older and younger persons may have differing attitudes. Making demands or appealing can be difficult for older who grew up in poorer living conditions. The idea of appealing can be professionally problematic as well. Many appeal cases resulted in an offer of NH placement (County Governor in Hedmark 2005). This indicates that nurses' professional appraisals are sometimes

set aside. When the County Governor considers appeals, the situation of the other older on the waiting list is unknown. Some nurses found this unfair and frustrating.

### *Use of coercion*

When older refused NH placement, even for respite stays, the situation became complicated. Few carers could tolerate the idea of forcefully placing their loved ones. In Norway, as a general rule, health care may only be provided with patient consent. It is illegal to use any kind of constraint, force, or pressure in medical treatment and activities of daily living (ADL) (Ministry of Health & Care Services 1999a). A study of the incidence of constraint in Norwegian NHs reported that the use of force or pressure in ADLs was widespread (Kirkevold & Engedal 2004). The incidence has not been explored in home health services. Nurses in this study did not want to use coercion, but some experienced it as an ethical issue concerning justifiability when the older refused care, resulting in low quality and unjustifiable situations, such as an older woman with ADD who refused to shower. The Norwegian laws provide limited guidance for how nurses should act in these situations: The Health Personnel Act (Ministry of Health & Care Services 1999b) requires nurses to assess the situation in general and conduct their work according to the requirements of professional responsibility and diligent care, and the Act Relating to Patients' Rights (Ministry of Health & Care Services 1999a) states use of force or pressure is illegal. Nurses faced two incompatible principles: the principle of beneficence, defined as making decisions and pursuing courses of action in the best interest of the care recipient, versus the principle of autonomy, defined as the care recipient's right to self-determination (Barber & Lyness 2001). A study of nursing in three Norwegian nursing homes showed that nurses emphasized the principle of beneficence (Slettebø 2002). Recently, there has been preliminary work intended to change the Act Relating to Patient's Rights in Norway. It is likely that the use of force or pressure related to care of persons incompetent to give informed consent, such as older with ADD, will be legal, given that care is in the older's best interest (Ministry of Health & Care Services 2006). It may be that changes in this law will result in lower respect for autonomy of the older and increased use of coercion. It will be important for nurses, then, to uphold the integrity and dignity of the older, which is possible regardless of their ability to act autonomously (Randers & Mattiasson 2004).

It is difficult to draw a line between the use of coercion and persuasion. Some nurses said they accepted the use of persuasion when older refused NH placement. One nurse even said that

nurses sometimes used verbal threats to make the older cooperate, which is illegal. This is in accordance with findings of an English study (Aveyard 2005). When older were competent enough to give consent refused care, their nurses often did not respect it but instead used persuasion. Although this was potentially unlawful, they often used additional pressure until the older submitted to the procedure. When the older could not consent, nurses attached a disproportionate significance to carers' views without advocating for carers' right to make decisions on behalf of the older (Aveyard 2005).

Another ethical issue occurred when the older were incompetent to give informed consent. In such situations, their next of kin could consent on their behalf. Health care must be deemed to be in the older's best interests, and it must be likely that the older would have given permission for such care (Ministry of Health & Care Services 1999a). Some older in this study had often stated they would never move into a NH, and in spite of ADD, they still were reluctant. In such cases, it was difficult for carers to consent on the older's behalf. Although NH placement could be in the older's best interests, carers knew the older would never have given permission for it. One relevant question was 'How realistic are the older's pictures of NHs?' A Chinese study showed that older who had negative NH-related beliefs lacked personal experiences with NH conditions (Tse 2007). In addition, attitudes can change with new experiences. Researchers who investigated the stability of people's preferences for life-sustaining treatment showed that people had great difficulty predicting their preferences for a future with changing conditions (Fagerlin & Schneider 2004). Thus, the statements from the older with ADD who said they would not move into a NH could be a reflection of their earlier opinions and not based on what the older really want in their present situations. This raises ethical issues of autonomy and beneficence. Should carers respect what the older stated before diagnosed with ADD, or should they prioritize beneficence in the present situation? Balancing these ethical issues was a difficult experience for carers.

### **Verification strategies**

Morse et al. (2002) proposed five verification strategies to ensure rigor in qualitative research: methodological coherence, sampling sufficiency, data collection and analysis, thinking theoretically, and theory development. Methodological coherence ensures congruence between the research question and components of the method. Semi-structured interviews were suitable for exploring the research question. To obtain an appropriate sample, we chose

participants from diverse contexts with varying kinship to the older and various waiting times for NH placement, thus providing a broad perspective on the experience. Saturation was reached. During data collection participants were encouraged to freely narrate their experiences giving care to the older, which provided rich textual data. In an interpretive process, co-authors who were experienced in elderly research and the method read and sensitively reflected on data. Analysis and interpretations were checked and discussed until we reached consensus. Quotations from the text support the categories and themes. Thinking theoretically, categories constructed from data and ethical issues emerging through the analyses were linked to existing literature (Morse et al.2002). While the context for this study was in Norway, these findings may be transferable to similar settings. Information about the research process and the Norwegian society allows readers to appraise the study's transferability (Graneheim & Lundman 2004).

### **Limitations**

The main limitation of this study is that we did not interview the older. Recommendations for further research are to interview older cared for at home to illuminate their experiences and preferences regarding NH placement.

### **Conclusion**

This study explored nurses' and carers' appraisals concerning if and when NH placement of the frail older awaiting NH placement was needed, and it illuminated ethical issues involved in deciding NH placement. Situations of the older and their carers varied, and conducting the appraisals seemed to be complex tasks. For some older people, nurses and carers agreed that NH was their needed level of care and that NH placement was urgent, while for others they disagreed. For various reasons, some older on NH waiting lists could not be placed in NHs even when beds became available. Many carers were ambivalent about NH placement because they feared use of coercion. Comparisons of carers' and nurses' appraisals of older awaiting NH placement contribute to a broader understanding of the ethical issues of justice, equality, autonomy, beneficence, and justifiability in nursing involved in decision-making concerning NH placement.

This study raises important issues for nurses to consider. Nurses must be aware of and discuss ethical issues involved in deciding NH placement. Regardless of insufficient resources for home health care, nurses should co-operate with carers and provide appropriate support for

older and their carers during the waiting period. In view of various situations, nurses must respect carers' appraisals and choices, and they must argue for the timely NH placement of the older. In addition, nurses need to acknowledge an ethical responsibility to contribute to policy changes by advocating for increased funding in elderly care.

### **Contributions**

Study design: AMSF, KN, NH; data analysis: AMSF; manuscript preparation: AMSF, NH, AN, FG, KN. NH, KN and AN regularly met with AMSF for discussion, support and supervision throughout the complete process.

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**Table 1 Description of older people, carers and nurses**

<b>Older people</b>	<b>Number of participants</b>	<b>Ages</b>
Women	8	71 – 99
Men	3	74 - 88
Living alone	7	
Living with spouse	3	
Living with child	1	
Low physical function	2	
Complicated clinical picture	3	
Advanced dementia disease (ADD)	6	
<b>Carers</b>		
Wives	3	70 – 79
Sons	3	60 – 62
Daughters	5	44 - 72
<b>Nurses</b>		
Registered nurses	7	30 – 45
Enrolled nurses	4	24 - 36
Women	9	
Men	2	
Years worked in home care	1 – 17 years (median 5)	

**Figure 1 Examples of two levels of codes, sub-categories and a category of appraisals of needs of nursing home placement**

<b>Category</b>	<b>APPRAISING NURSING HOME TO BE THE LEVEL OF CARE NEEDED</b>			
<b>Sub-category</b>	Presenting reasons for urgent NH placement	Indicating carers' situations	Appealing	Describing nurses' frustrations
<b>Codes level 1</b>	Unworthy lives Unjustifiable situations The older people want NH placement NH placement at the right time Worrying that something might happen to the older	Carer's health problems Exhaustion Troubled conscience	Complaining without result Using media Knowledge and resources Justice versus injustice Ethics Professional appraisals set aside	Lack of NH beds Not being able to do a satisfying job Troubled conscience Change of workplace?
<b>Codes level 2</b>	Unworthiness Is the situation justifiable? The older's wishes Before becoming bedridden Before too cognitively impaired Needing training Worrying about nutrition Worrying about falls Worrying about fire	Disturbed sleep Care 24 hours a day Helplessness Stretched to the border Alone with the responsibility Living to close Crying Not doing enough Setting limits for home health care	Frustration Helplessness Informed content Who have the greatest need?	Helplessness Not doing enough for the older Prioritizing Professional appraisals set aside Justifiable situation?

**Figure 2 Sub-categories, categories and themes of appraisals of needs of nursing home placement**

<b>Sub-categories</b>	<b>Categories</b>	<b>Themes</b>
Presenting reasons for urgent NH placement Indicating carers' situations Appealing Describing nurses' frustrations	Appraising NH to be the level of care needed	Ethical issues concerning justice  Ethical issues concerning autonomy
Experiencing love, companionship and duty Not needing NH placement according to nurses	Appraising the older as able to continue living at home	Ethical issues concerning beneficence
Concerning about NH conditions Economic consequences	Being ambivalent about NH placement	Ethical issues concerning equality
Refusing NH placement Persuasion and threats Accepting an offer regardless	Being sceptical about use of coercion regarding NH placement	Ethical issues concerning justifiability in nursing