Ethical challenges in acute and long-term care of the elderly: a scoping review

Sfide etiche nell'assistenza agli anziani in contesto acuto e residenziale: una revisione di scopo

Federico Pennestrì[1] Noemi Giannetta[2] Giulia Villa[2] Duilio Fiorenzo Manara[2]
Roberta Sala[1] Roberto Mordacci[1]

1. Faculty of Philosophy, Vita-Salute San Raffaele University, Milan, Italy.
2. Center for Nursing Research and Innovation, Faculty of Medicine and Surgery, Vita-Salute San Raffaele University, Milan, Italy.

Corresponding author
Federico Pennestrì, PhD,
+39 338 22 35 287
Email:
pennestri.federico@hsr.it

ABSTRACT

Introduction: The discontinuity between the high ideals of nursing education and real-world practice is a major cause of frustration, moral distress and burnout among the youngest, and pushes up to half nurses to change career within two years. These conditions are accentuated in the care of elderly patients with multiple chronic needs.
Method: A multidisciplinary team of nurses and philosophers investigated the chronic determinants of ethical issues in aged care nursing, building on insightful experiences from different institutional settings, in order to provide evidence for contextualized and patient-oriented professional support. A scoping review protocol was employed at this purpose.
Results: Most of the environmental and organizational deteminants of chronical ethical issues are outside the control of nurses, and most of the relational ones follow as a result in both settings. Many of the them have been confirmed and further aggravated by the COVID-19 pandemic.
Discussion: Although there are not universal solutions to the issues described, still it is possible to distinguish which determinants fall within the control of nurses, to help them prevent or manage their occurrence; and what are beyond, to help them avoid self-blame and transfer constructive information to those who can intervene.
Conclusion: Education can help exercise critical thinking and communicate properly. However, once maximized team cooperation, organizational efficiency and individual soft skills, diminishing room for improvement will be available at increasing human and financial costs. Improving the condition of nurses is an urgent political responsibility and requires a broader socio-cultural change.
Keywords: burnout, COVID-19, elderly, moral distress, workplace health promotion.

RIASSUNTO

Introduzione: La frattura fra educazione infermieristica e realtà lavorativa quotidiana rappresenta una frequente causa di frustrazione ed esaurimento psicofisico, che spinge fino a metà degli infermieri a ritirarsi entro due anni dal conseguimento del titolo. Tali condizioni sono accentuate nell'assistenza alla persona anziana affetta da bisogni cronici e complessi.
Metodo: Un gruppo multidisciplinare di infermieri e filosofi ha studiato i determinanti ambientali, organizzativi e relazionali alla base dei problemi etici che emergono con maggior frequenza nell'assistenza alla persona anziana, sia nelle strutture per acuti, sia nelle strutture di ricovero a lungo termine, alla ricerca di evidenze utili a migliorare le condizioni dei professionisti. A tal proposito è stata una condotta una revisione di scopo.
Risultati: La maggior parte dei problemi ambientali e organizzativi risultano essere al di fuori del controllo dei singoli infermieri, e la maggior parte dei problemi relazionali ne rappresentano la conseguenza. Molti di questi problemi sono stati confermati e aggravati dalla pandemia di COVID-19.
Discussione: Sebbene non vi siano soluzioni trasversali a tutti i contesti, resta possibile distinguere quali problemi rientrino nel dominio di azione degli infermieri, per aiutarli a prevenirne o gestirne l'occorrenza; e quali invece vadano oltre, onde evitare sentimenti di autoaccusa, e trasferire informazioni utili a coloro che invece possono di volta in volta intervenire.
Conclusioni: La formazione può allenare il pensiero critico e la comunicazione fra operatori, pazienti e familiari. Una volta raggiunti i massimi livelli possibili di cooperazione ed efficienza, tuttavia, margini di miglioramento sempre più ridotti saranno acquisiti a costi umani ed economici sempre maggiori. Il miglioramento delle condizioni degli infermieri dipende sempre sempre più da investimenti allocativi e culturali urgenti.
Parole Chiave: anziani, COVID-19, esaurimento psicofisico, politiche allocative, salute sul luogo di lavoro.

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INTRODUCTION

Nurses are the healthcare professionals who spend most of the time in direct contact with patients and residents, administering drugs at bedside, supporting the activities of daily living (ADL), clarifying fundamental information and mediating the needs of patients with doctors, coordinators and families. This is why nurses are traditionally considered "patient advocates", and receive undergraduate education on the moral values intrinsic to their practice (Gibson, 1993).

Once nurses start working, however, they often discover that these values are chronically jeopardized by the reality of daily work, made of financial constraints, supply cuts, spatial limitations, pressing timetables and demanding interpersonal relations (with patients, residents, families, colleagues, doctors and managers), that put into question what their advocay does actually consist in (Kalaitzidis et al., 2015), if they are given the authority needed to act upon it (Hughes, 2008), and the extent to which fondamental nursing values can be ordinarily sacrificed to legal and technical obligations (Snelling, 2016).

The contrast between what nurses have been educated to do (and may feel appropriate to do for a certain patient, in a certain moment) and what the local environment and organization allow them to do (for that patient, in that moment) originates consuming dilemmas described in literature as moral distress (Morley et al., 2019; Fourie, 2017; Jameton, 1984), gradually resulting in loss of motivation, reduced work efficacy (Mudallal et al., 2017), job strain, increased exposition to cardiovascular disease (Theorell et al., 1996) and psychophysical burnout (Wagner, 2015; Saarnio et al., 2012). The frustration of the "high ideals of the profession" is common to the most-educated healthcare professionals, is a major cause of burnout among the youngest (Perni et al., 2020; Freudenberger, 1974) and pushes up to half nurses to change career within two years from graduation, one in five within the first (American Nursing Association, 2017a).

This condition is accentuated in the care of elderly patients with multiple chronic needs (physical, psychological and social), whose interests are often unclear (i.e, because of cognitive dysfynction and fluctuating autonomy), when it's difficult to understand what needs shoud have priority (i.e., safety v. freedom), when colleagues and relatives even disagree on who or what should be protected first (Perni et al. 2020; Harrad et al., 2018; Rees et al., 2009). The "everyday ethics in the care of the elderly people" have been recognized as a new frontier of study for bioethics (Bolmsjo et al. 2006) and a fundamental topic to be introduced into undergraduate education (Rees et al., 2009), in order to help nurses meet a steady increase in elderly patients further aggravated by the fragmentation of institutional care and the social fabric erosion (Lawless et al., 2020; Harvard Women's Health Watch, 2019).

It is pointless to educate nurses to become the patient's advocate when they have more responsibilities than authority (Corley, 2001), as this generates stress, demotivation, and feeds misunderstandings with patients, colleagues and families (Van Humbeeck et al., 2020; Abma et al., 2012; Saarnio et al. 2012; Sokolowski, 2012). Besides 'traditional' issues such as tube feeding, end of life or resuscitation, more frequent but equally problematic 'everyday issues' are consuming nurses 'in the mundane', as complex patients are becoming more the rule – rather than the exception – of their daily practice (Perni et al., 2020; Dauwerse et al., 2012; Bolmsjö et al., 2006).

Moral distress and burnout represent not only a problem for the wellbeing of nurses (poor personal value), as they are associated with reduced quality and safety of care (poor technical value), higher turnover and rehabilitation costs (poor allocative value), lack of energy, time and motivation to devote to home care giving or other social activities (poor societal value). Therefore, understanding and addressing their origins is a key investment to increase the value of nursing care and education (Ives Erickson, et al., 2020; European Commission, 2019; Jangland et al., 2018; Whitehead et al., 2015; Pappas 2013). Taking care of patients requires taking care of providers (Bodenheimer et al., 2014), and taking care of providers requires taking care of the workplace environment (WHO, 2010; Rushton, 1995).

The aim of this work is to investigate environmental, organizational and relational determinants of emerging ethical challenges in nursing care of the elderly, including different institutional settings, distinguishing what determinants are under the control of nurses and what not, what should be addressed by education and what by other interventions, be them managerial, in order to update the nursing curriculum and meet the demand for patient-oriented, contextual care.

METHODS

A multidisciplinary team of nursing coordinators, researchers, moral philosophers and educators performed a scoping review to retrieve a literature baseline in support of an ethical training program for nurses willing to work with elderly patients.

Scoping reviews are employed to map and synthesize the scientific literature in order to address further research and/or empirical intervention, including local policy and education. This methodology has already been employed to describe job-related psychological disorders such as stress, trauma exposure and depersonalization (Léonard et al., 2020), and improve the quality of life and care assuming the perspective of the elderly (Hausknecht et al., 2020; Lawless et al., 2020; Teater et al., 2019). Following the protocol described by Colquhoun et al. (2014), the synthesis is organized into the five steps detailed in Table 1.

RESULTS

Of the 26 studies included in the synthesis, 14 are based on LTC settings (nursing homes, residential or semi-

Table 1. Scoping Review Protocol

Identifying research question	What are the environmental, organizational and relational determinants of ethical challenges faced by nurses in their daily practice with the elderly?
Identifying relevant studies	Given that the focus of investigation is about non-clinical determinants of ethical issues in daily practice, qualitative studies, case reports and philosophical essays in nursing ethics from all institutional settings were preferred to quantitative, biomedical studies focusing on age-related disease or pharmacological trials. Qualitative research is indicated to express insightful experiences related to moral dilemmas and emotional exhaustion (Rees et al., 2009). End-of-life studies were also excluded from this research, in order to shift the focus of bioethics from traditional but glaring issues (such as therapeutic obstinacy and treatment withdrawal) to the more common dilemmas which consume the operators in the mundane (Dauwerse et al., 2012; Bolmsjö et al., 2006).
Study selection	Two electronic databases (Jstor and Philosophical Index) were searched for the string "(nursing OR caregiving) AND elderly AND (ethics OR moral)". The keyword "caregiving" was employed in order not to exclude potential studies which could refer a) to nurses as caregivers; b) to caregivers as teams of professionals in general, including nurses; c) to different degrees of professionals in the field, from nursing coordinators to certified nursing assistants, as they assume different titles according to the country and setting they work in, but are exposed to the ethical challenges before mentioned. Papers in English including clear correlations between environmental, organizational and relational determinants and moral challenges were included in the synthesis, resulting in 26 final studies.
Charting the data	The studies are charted in Table 2, reporting metadata about author and year, type of study, health and/or social care setting, principal aim, professionals involved and country.
Collating, summarizing, reporting	The determinants of ethical challenges in the care of the elderly are collated and summarized according to the setting where they are reported (acute; LTC; both settings). Although these determinants do often overlap, the authors consider this framework helpful to provide an easy-to-read, evidence-based support for nurses, researchers, educators and/or managers to act and/or research accordingly. When a clear distinction between nurses and care givers is not provided by the original study (i.e., to refer to common team challenges), the inclusive term "operators" is employed.

residential care for the elderly, rehabilitation centres for chronic disease, dementia care units, home care), 4 on acute settings (hospital wards, geriatric acute care, community clinics), 5 on both, 3 are non-specific (2 essays, 1 review). Most of them are qualitative studies (10), 7 are essays, 4 case reports, 4 literature reviews, and 1 is a mixed-method study (Table 2). The ethical challenges reported by the studies are described in Table 3. Similar experiences reported twice or more are collated and summarized in a single line.

DISCUSSION

While the impact of the environment and organization of (though excellent) healthcare on elderly patients is relatively well known (Pennestrì, 2021; Lawless et al., 2020; Teater et al., 2019), less so on the wellbeing of caregivers. Doctors' decisions (sometimes inconsistent with the patient's true good, as perceived by nurses); lack of financial and human resources (driving nurses to sacrify the quality of time they spend with patients to the quantity of tasks they have to perform in between); tension with families (following incomprehensions or inconsistent views on the patient's good); societal and organizational attitudes (the drive for efficiency and productivity is detrimental to responsiveness and trust); routine-centred care (procedures are sometimes taken for granted even though the benefits on patients are unclear); and relations with peers (colleagues exerting pressure to hide poor quality of care, or holding different views about the patient's true good); are confirmed determinants of ethical issues reported by nurses assisting elderly patients in different institutional settings (Rees et al., 2009).

Ethical issues determined by routine-centred care (permanent personnel shifts; lack of responsiveness towards patients, and coordination among care givers); societal and organizational attitudes (recovery expectations are frustrated by fragmented and underfunded post-acute care, and the negative reputation surrounding nursing homes); and tension with families (as they generally have more influence on the resident's care plan in comparison to hospital care; and may feel culpable for not being able to assist adequately their beloved) are accentuated in long-term care (LTC). Task-oriented, reductionist approaches to treatment may be suitable with temporary, disease-oriented hospital care, but they fall short in LTC, as 1) residents' needs are often complex and interacting (not only physical, but also psychological and social); 2) are based (and can evolve) on a longer time span; 3) residents can place more emphasis on psychosocial needs than on biomedical treatment itself, especially when they want to live the remaining years while maintaining the habits they find most important (i.e., food preferences, rest frequency and duration, as much as possible of the home environment), even at the cost of reducing medicalization, notably when the latter (i.e., invasive pharmacological treatment) is detrimental to the former (O'Neill et al., 2020; Shin, 2015; Gawande, 2014). This is why the concept of autonomy traditionally adopted in acute care settings (as informed consent or dissent to treatment) (Jecker, 1997) may not be helpful in LTC, where autonomy is not primarily contractual, but relational in nature (Austin, 2012), since residents need structural, ongoing support from care givers in order to satisfy their needs (O'Neill et al., 2020; Shin, 2015; Ter Meulen, 2008) (and sometimes from other residents) (Abma et al., 2012).

Most of the environmental and organizational deteminants here described are outside the control of nurses, and most of the relational determinants follow from the formers, in both settings. Although there are not universal solutions to the issues resulting from the synthesis, still it is possible to distinguish what determinants fall within the domain of nurses, to help them prevent or manage their

Table 2. Study included

Author and year	*Setting*	*Professionals involved*	*Principal aim*	*Type of study*	*Country*
Boddington et al., 2018.	Acute hospital wards	Nurses and HealthCare Assistants (HCAs)	To investigate how ward staff is responsive to the needs of patients affected by dementia.	Qualitative study	England and Wales
Lo et al., 2018.	Hospital, community clinics, public health, other	26 bilingual nurses	To discuss the extent to which bicultural professionals can improve the care of bicultural patients.	Qualitative study	United States (U.S.)
Rushton et al., 2018.	Geriatric acute settings	Nurses	To reconcile the concepts of good ethical conduct and person-centred care of patients affected by cognitive impairment.	Essay	Non country-specific
Hadolt et al., 2017.	Nursing homes	Nurses	To explore how market thinking and time-oriented care impact on the relations between nurses and elderly patients.	Case report	Denmark
Chivers et al., 2017.	Nursing homes	Nursing home professionals	To describe the negative impact of the media representation of the nursing home on relations and trust between healthcare staff and residents' families.	Essay	Europe and U.S.
Rushton et al., 2016.	Geriatric acute settings	Nurses	To reconcile the concepts of time-oriented care and person-centred care of patients affected by cognitive impairment.	Essay	Non country-specific
Dominguez-Rué et al., 2016.	LTC	Nursing home professionals	To explore how interior design and motion technologies can improve care of patients affected by dementia.	Essay	Germany
Van der Dam et al., 2014.	Residential and semi-residential elderly care.	Residential care professionals	To review the international literature on ethical supporting tools provided to the professionals working with elderly patients.	Review	International
Saarnio et al., 2012.	Public and private health centre wards, nursing homes, and dementia care units.	Registered Nurses and locums.	To explore the degree of stress of conscience spread among the staff caring for older patients in Finland.	Qualitative study.	Finland.
Goethals et al., 2013.	Acute elderly care	Geriatric nurses	To explore the ethical reasoning process of nurses in case physical restraint is needed in acute elderly care.	Qualitative study	Belgium
Van der Dam et al., 2012.	Nursing and residential homes	202 care providers, from physician to nursing assistant	To describe situations in which eldercare professionals struggled with the question "what should we do"?	Qualitative study	Netherlands
Van der Elst et al., 2012.	Acute geriatric care and nursing home	Residents	To review the literature on how do patients perceive the "good nurse".	Literature review	Non country-specific
Abma et al., 2012.	Residential home	A staff member.	To describe why – in nursing homes – residents' autonomy is more than just making decisions without others interfering.	Case report	Netherlands
Sokolowski, 2012.	Residential care	Multiprofessional staff	To describe how – in nursing homes – residents' autonomy is different from autonomy outside the nursing home.	Case report	Canada
Dauwerse et al., 2012.	Elderly care organizations.	Certified nurses and nursing assistants	To investigate whether the ethical supporting tools available the professionals do actually meet their needs.	Mixed methods study	Netherlands.
Stenbock-Hult et al., 2011.	Multiple eldercare settings	16 nurses	To describe the concept of vulnerability in nurses caring for elderly patients and residents.	Qualitative study	Finland
Van der Cingel, 2011.	A rehabilitation centre for chronic diseases, a home care organization, an outpatient clinic.	Nurses	To describe the concept of compassion in nurses caring for elderly patients affected by chronic diseases.	Qualitative study	Netherlands
Jakobsen et al., 2010.	A nursing home	23 Staff members.	To describe how health and social care professionals discuss about ethical issues; how they derive their self-perception from colleagues and managers; how this can incentive or disincentive speaking out or interiorizing problems.	Qualitative study	Norway
Rees et al., 2009.	Multiple settings	Nurses	To review the typical ethical issues arising in the care of older people, and support the inclusion of ethical care of older patients in the curriculum of undergraduate students.	Review	Non country-specific
Rodriquez, 2009.	2 Nursing homes	65 staff professionals	The explore how the concept of agency is employed by the nursing staff in order to attribute responsibility to the outcomes of care and the aggresiveness of patients.	Qualitative study	U.S.
Ter Meulen, 2008.	Health and social care.	Health and social care professionals.	To describe the negative impact of consumerism on the quality of care of elderly patients.	Essay	United Kingdo
Bolmsjö et al., 2006.	A nursing home	Non-specified staff	To describe how LTC professionals suffer from ethical dilemmas and tragic choices, and how the broad workplace environment, adequate regulation and ethical training can reduce their stress.	Qualitative study	Sweden
Sammet, 2007.	2 Nursing homes	Nurses	To describe how a Federal Court of Justice gave morally inconsistent pronunciations for bad care outcomes in similar	Case reports	Germany
England, 2005.	Non-specified setting	Non-specified care givers	To describe frequent motivational determinants of good and bad care in terms of moral values and environmental constraints.	Review	Non country-specific
Glenn, 2000.	Non-specified settings	Family caregivers	To build on the burden of dual care givers to support for public funding of home care givers, especially female.	Essay	U.S.
Oliver, 1999.	Nursing home	Certified Nursing Assistants (CNAs)	To support that quality of care in nursing homes can improved by extending job satisfaction assessment to CNAs.	Essay	U.S.

Table 3. Environmental, organizational and relational determinants of ethical issues in the care of the elderly. Section 1.

Environmental, organizational and relational determinants of ethical issues in the care of the elderly	
Experience	*Ethical Issues*
Acute settings	
When admitted to hospital, old patients affected by cognitive impairment are subject to standard operational procedures, uniform clinical protocols, and task-oriented professional workshifts.	Nurses are in the position to better intercept the impact of impersonal, discontinuous care on fragile patients, and provide decision makers with useful insights to improve quality and integration of care.
Nurses are closer to the needs of these patients in comparison to doctors or the administrative staff who sets the rules.	Nurses can feel stressed when recommendations they feel useful are not taken into consideration.
Standard procedures based on measurable biomarkers reduce complex, fragile patients to material aggregates of organs, tissues and cells (curing *what* is ill).	The pushing timetable of diagnostics and therapy remove the time for "being with" the patient, which is an essential relational dimension of nursing (caring for *who* is ill).
Patients (even when affected by cognitive dysfunction) appreciate the efforts of nurses to turn technical tasks into time spent together, not necessarily dedicating *more* time in quantitative terms (more minutes), but *better* time in qualitative terms (i.e., asking how they feel while a certain procedure is performed).	When nurses are unable to *care* for patients, and not only to *cure* their symptoms or disease, they can feel powerless and lose motivation.
Poor or absent clothing, lack of privacy and inadequate toilet facilities turn continence care into something exhibited.	Operators who can do nothing to change the environment, and cannot prevent incontinence on time, feel powerless and empathetic to the patients' psychophysical vulnerability.
People affected by dementia are piecewise aware of this condition, which may be associated with a loss of dignity.	
Applying physical restraints enable nurses to 1) preserve the patient's safety from falling, harming other patients or self-harming; 2) assist more patients at the same time.	However, applying physical restraints is unpleasant for patients, difficult to perform by empathetic caregivers and subject to misinterpretation in part of families.
Long term care	
Healthcare is subject to increasing legal obligations (i.e., registering each task performed) which also provide information in support of a wide range of financial assessments (i.e., cost-effectiveness, time-driven activity-based costing).	Avoiding reflection is a spread form of adaptation to the duties imposed by managers, and it is professionally rewarded.
The dictate of efficiency pushes operators to focus only on the technical tasks they are given, and not to think about whether/how much what they do every day really makes the person they assist feel good.	Motivation and lack of motivation are empathetic. Some operators who do not easily relinquish their education and values, and disapprove when colleagues and/or team members deny them too.
Nurses need to know residents in order to 1) capture implicit needs or predictive symptoms on time, 2) recognize the real needs of each resident, and 3) provide effective, personalized care.	Nurses have to perform task-oriented, technical tasks as if they were parts of an assembly line, as if one operator were the same as the other.
Residents are worried about constant staff replacement, and prefer to be looked after by people they already know.	This is often detrimental to effective care and trust from residents.
Lack of coordination between acute care and post-acute care is considered by all healthcare professionals detrimental to the quality of care.	Frustrated expectations are often discharged on nursing home operators, who in turn often discharge it on the lowest-educated and paid workforce (i.e., CNAs), however serious may their efforts actually be.
Expectations towards effective post-acute care are often frustrated by the reality of limited resources available to nursing homes and residential care units.	
Families can also feel not to have cared for their beloved successfully.	
Interpreting aggressive behavior as non-intentional (i.e., in terms of alterated physical function such as degenerated brain tissue) can help the staff to accept and manage some residents' outbursts, as these are considered beyond their will.	The responsibility towards actions, much more than actions themselves, is given moral value. This is helpful to maintain control and preserve motivation.
In case of bright and alert patients, it is worthy considering their needs and wishes to have substantially changed as a (more or less conscious) strategy to cope with their transition into a new life.	Most care providers are educated to conceive autonomy as a dichotomy: a person is either autonomous or not. However, autonomy in residential care is different – and more fluid - from autonomy outside residential care or during temporary hospitalization.
In case of patients affected by cognitive dysfunction and fluctuating self-control abilities, that dicotomy is even less helpful for operators to recognize and protect their interest.	
People affected by dementia may suddenly need to move, and movement is associated with many psychophysical benefits. However, it unsafe for these patients to move alone.	Operators may find it difficult to weight the pros and cons of allowing patients to move, which may be direct (falls, general safety) or indirect (helping or monitoring a patient can leave other patients negltected), as all these actions are given moral value.
Due to staff shortage, operators have no time to reflect about the problem, or even be unaware of residents' movements. Time and space constraints put them at risk of doing wrong whatever choice they adopt.	
The collective representation of the nursing home largely relies upon reports from the media, which are strongly influenced by need of newsworthiness, abuse, scandal, and poor standards of care.	Tension between faimilies (who may feel to have failed to look after their beloved, exposing them to risks) and staff (who may feel ungratefulness and disproportionated expectations from families) is facilitated to rise.
The impossibility to assist each resident at the same time requires the operators to distingush and meet the most urgent needs first, pick up implicit messages or symptoms, and avoid to care for "those who shout loudest" before.	Distinguishing whether this inability is descriptive ("this is the reality of nursing homes") or normative ("this is morally acceptable") is fundamental to determine the responsibility of operators and institutions against potential injuries.
Sometimes, critical risks follow (i.e., patients lifting bed rails or falling in the bathroom).	

Table 3. Environmental, organizational and relational determinants of ethical issues in the care of the elderly. Section 1.

Environmental, organizational and relational determinants of ethical issues in the care of the elderly	
Experience	*Ethical Issues*
Long term care	
Both acute and long-term care	
Consumerism turned the caring relationship between into a contractual relationship based on rights (to receive or not certain treatments and activities) and obligations (to perform these treatments and activities). A market-based view of care may be occasionally appropriate in hospital care (i.e., elective surgery).	A contractual relationship is not suitable with complex patients in need of integrated health and social care, whose needs do evolve continuously along with the resources available in each facility and the professionals here employed.
When patients and residents are not particulary vulnerable, they enjoy the highest level of self-care as possible, and appreciate nurses who allow them to do that.	The difficulty to assess the degree of independence of the elderly offers an opportunity to neglect care under apparent moral reasons, which is a coping strategy under time constraints.
At the same time, patients and residents complain about operators who neglect their needs and justify with the intention of promoting independence.	This is morally distressing for empathetic and motivated caregivers.
A good assessment of the independence degree of elderly patients and residents is key to find an acceptable balance between their quality of life and safety.	The more nurses are sensitive to the vulnerabilities of patients, the more they experience stress. The less nurses are sensitive to the vulnerabilities of patients, the less they are responsive to their needs.
Second generation immigrants are considered natural candidates to provide culturally sensitive care to coethnic patients.	Bicultural nurses cope with the ethical challenges associated with cultural habits and expectations in different ways:
On the one side they may pick implicit expectations from patients, mediate cultural habits, reduce non-compliance to therapy and translate medical jargon into plan, comprehensible language.	prioritizing ethnic bonds, prioritizing professional norms, or acting without moral reflection or consistency.
On the other side, they are aware of local guidelines and professional conduct requirements.	
Dual workers providing care at their home and outside, especially women, are overburdened by the need to earn money and meet care responsibilities. This is a predictor of burnout and high turnover. The more distance between home and work, the more risk.	Financing home caregiving could reduce the psychophysical burden of dual workers, and preserve their motivation and focus at work.

occurrence; and what goes beyond, to help them avoid frustration, self-blame, and transfer useful, constructive information to those professionals who can intervene, be them peers, nurse coordinators, educators, doctors or managers.

The more nurses recognize the boundaries of their responsibilities, the more they can a) shift the focus from frustration to gratification, which is a relevant protective factor for the mental health of professionals (Barello et al. 2020); b) remember that nursing is itself a moral activity, and be aware of the importance of their efforts to elderly residents and patients, even though they may not be able to recognize them: taking care of the elderly has unique ethical challenges just like unique emotional reward (American Nursing Association, 2017a; Eldh et al., 2016; Stenbock-Hult et al., 2011); c) weight which value behind equally moral but antithetic actions has priority in non-ideal situations (i.e., physical safety or psychological wellbeing) (Goethals, 2013; Di Censo, 2003; Gibson, 1993); d) be ready to provide (and ask for) explanations when not all values can be respected to the same degree, and opt for the best compromise (Goethals, 2013).

Nurses at bedside of patients are able to capture their needs better and before than many other decision makers, contributing to improve quality of care, organizational efficiency and team coordination, provided appropriate mediation to meet bottom-up recommendations and top-down solutions (Rushton et al., 2018). At this purpose, it is fundamental to exercise critical thinking and communicate properly, and education can provide substantial support (Profetto-Mc Grath, 2005; Macer, 2008). Many frameworks have been proposed to support well-founded moral decisions, from individual (Chrisham, 1985) to group schemes (Van Der Dam et al., 2014), as acting on a clear set of principles is associated with reduced moral stress, improved cooperation (Van der Dam et al. 2014), increased confidence and nurse accountability (Lasala, 2009). These frameworks may not be effective to guide problem solving in emergency care, where personal experience and intuiton are more suitable (Nibbelink et al., 2019). But this is precisely why they are effective in support of the management of chronic ethical challenges, when there is more time to reflect, room for planning, need for extended cooperation (including patient, resident, and relatives), and the same care needs may evolve over time. From the perspective of the professionals working with nurses, walking a day in nurses' shoes is a worthy trying experience to aling efforts and improve cooperation (American Nursing Association, 2017b). From the perspective of nurses themselves, learning to identify values behind actions is a fundamental bioethical skill to manage non-ideal chronic situations, as they help break down complexity, balance pros and cons, and improve the consistency of decisions at the individual and the team level (Goethals et al., 2013; Karadag et al., 2009; Macer, 2008).

The moral importance of giving and receiving explanations is confirmed by sick patients who file complaints more easily when they have not been listened to by their care givers (Levinson et al., 1997); nurses who are more prone to accept aggressive behavior when they know it is non-intentional (Rodriquez, 2009); relatives who accept that health worsening does not necessarily follow from lower care efforts (Charon, 2019); patients who are more

willing to comply with therapy when they receive clear and thorough information, just because they feel taken into consideration (Lawless et al., 2020), including multicultural mediation (Lo et al., 2018); patients who feel better just because their suffering is acknowledged, releasing frustration, interiorization and anger (Van der Cingel, 2011).

Moral reasons and technical explanations can be given from nurses to patients and families (i.e., why their cooperation is important, why a certain treatment is administered, withdrawn, or why are physical restraints applied); doctors or coordinators (i.e., when routine prescriptions may be inconsistent with the patient's wellbeing, building on the patient's immediate feedback and his/her personal knolwedge); and managers (i.e., why informative technologies and task-oriented care may become detrimental, rather than beneficial, to the quality and safety of care). Reasons should also be received, by nurses, from patients and relatives (i.e., what motivates an aggressive, unusual or harmful behavior); peers (i.e., why a better course of action is not adopted although possible); doctors and coordinators (i.e., why a painful procedure should be performed); and managers (i.e, why it's impossible to dispense with a physical barrier, rearrange shifts, or ensure adequate supplies).

Asking and giving reasons may not be always appropriate (i.e. during an emergency, or opening to the public) or feasible (i.e., to/from coordinators and managers), and requires the ability to communicate properly, either individually, or within one of the more or less formal meetings (from ethical committees to MCDs) designed to give voice to the operators' requests and suggestions. This is not a reason for giving up on communication, but to learn how to communicate, as once problems are made aware, they can be solved at the earliest useful opportunity, by the person best suited to do so, and release frustration before it undermines cooperation and quality of care. Therefore, the ability to understand if, how and when to communicate is a key soft skill worthy educating nurses before they start to practice, in order to maximize the benefits of the hard skills they learn at university.

This is even more true for nuses 1) who are willing to care for elderly patients, 2) in light of the increasing responsibilities they are given worldwide, be them primary care providers (Maier et al., 2016), chronic case managers (Pennestrì, 2021, David et al., 2020; Pennestrì, 2017; Murphy, 2004), or home care consultants (Cochrane et al., 2016). Elderly patients often find clear empathetic communication, good attitude, effective coordination among professionals and regular consultation with relatives as important as biomedical prescriptions themselves, even more when they are affected by chronic disease (Pennestrì, 2021; Straßner et al, 2019). Therapeutic adherence is an example of how biomedical care, to be effective, requires trust on part of the patient and clear communication from nurses, who are often appreciated precisely because of their ability to offer a reference point and meet concerns (Lawless, 2020; Holøyen, Stensdotter, 2018; Wodskou et al., 2014). If evidence-based medicine was the new trend in healthcare education from the early 20th century, promoting the team ability to take the best advantage from this evidence is a primary learning challenge in the 21th, both for nurses and doctors (Chang et al., 2018; American Nursing Association, 2017a; Irby et al., 2010; Di Censo, 2003)

LIMITATIONS

The scoping review was concluded before the COVID-19 pandemic put additional stress on the healthcare professionals who assisted patients and residents at the frontline, both in acute and LTC settings. The first CoViD-19 outbreak left many healthcare professionals burned-out not only for the extraordinary efforts they had to perform to care for their patients without any effective cure available (many of which were elderly patients), but also because they had to work under chronic lack of resources, space and time, describing comparable experiences to those from field hospitals (Litz et al, 2009) which resulted in severe psychophysical strain and unresolved moral conflict (Barello et al, 2020; Senior, 2020; Dean et al., 2020; Faralli et al., 2020). Nursing education itself was affected by the need to organize training remotely (Tomietto et al., 2020), or to suspend it precisely when the need was greatest.

Entire wards were re-organized in order to provide dedicated care and keep them separated (Pennestrì et al., 2021); many of them had to leave work because they were affected by SARS-COV2 infection, or left work to avoid it; managers had to find how to assist more and more patients with less and less personnel; many caregivers had to make themselves available without a specific expertise. In acute care settings, patients had to survive intensive care units without any contact with the outside, save nurses and doctors themselves, and nurses had somewhere to replace doctors exposing themselves to preventable, undue risks (Jia et al., 2020). In LTC, residents were isolated from families (and often from other residents) for months; many elderly patients were admitted in nursing homes because of the saturation of hospitals and home care service, pushing insufficient care givers to work with insufficient safety devices; managers had to urgently recruit personnel to replace or integrated them; the spread of preventable infections led to a "nursing home massacre" (Istituto Superiore di Sanità, 2020), even more in presence of a high population density and a significant presence of elderly inhabitants (Signorelli et al., 2020). Many professionals found personal gratification fundamental to bear this pressure (Barello et al., 2020).

This research supports the hypothesis that the COVID-19 pandemic alone did not determine the overload and burnout of caregivers at frontline, but rather represented the dramatic occasion which made already existing structural limits clear. The environmental, organizational and relational determinants here described should help distinguish which ethical challenges can be attributed to the COVID-19 pandemic and which are chronically

econuntered by nurses working with an increasing population of frail patients, with no specific education provided. If the first problem is hopefully contingent, the second is structural, and needs to be addressed urgently.

A first solution is keeping the elderly as much as possible outside hospitals and nursing homes, investing on prevention, home care services (Cochrane et al. 2016), integrated social and health care (Pennestrì, 2021), community care (Wiles et al., 2011), or family caregivers qualification and remuneration (Glenn, 2000). When resources are shared, a second complementary solution could be to revise the allocation of public-funded care in general investing on public health education (starting as early as possible in schools), on value-based priorities and on introducing the responsibilization of harmful behaviors (European Commission, 2019; Bognar et al, 2014; Daniels, Sabin 2008). When limited resources are chronically withdrawn to care for patients who repeatedly adopt harmful behaviors, refuse to vaccinate, or refuse to meet basic safety measures during epidemics, and nurses put at risk their psycophysical health everyday precisely as a consequence of this, this allocation is morally questionable.

CONCLUSIONS

Structural limitations outside the domain of nurses prevent many of them to act on the values they were educated to. Other nurses relinquish these values to avoid chronic stress and pursue easier professional reward. These conditions are accentuated by the care of elderly patients admitted to acute and LTC settings, which pose consuming ethical issues. However positive may be the attitude of nurses, the review confirms that these issues result from the combination of four variables: nurses, facilities, education and care demand (Adibelli et al., 2013). Investments in technologies, interior design and facility supplies can reduce the negative impact of some environmental and organizational issues on a local base, but the question remains whether these investments can withstand the impact of an increasingly large and complex elderly population.

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