Empirical Paper

Meanings of troubled conscience in nursing homes: nurses' lived experience

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Abstract

Background: Troubled conscience among nurses and other healthcare workers represents a significant contributor to healthcare worker moral distress, burnout and attrition. While research in this area has examined critical care in hospitals, less knowledge has been obtained from long-term care contexts such as nursing homes, despite widely recognised challenges with regard to vulnerable patients, increasing workload and maintaining workforce sustainability among nurses.

Objective: The aim of this study was to illuminate and interpret the meaning of the lived experience of troubled conscience among registered nurses (RNs) working in nursing homes.

Research design: This qualitative research employed narrative interviews with eight nurses to obtain essential meanings of their lived experiences of troubled conscience. The interview texts were analysed using a phenomenological hermeneutic approach.

Ethical considerations: Participation was voluntary, informed and was conducted with written consent. The Norwegian Centre for Research Data approved the data processing of personal data.

Findings: The analysis uncovered two themes: (1) troubled conscience means abandoning ideals, with the subthemes: failing dependent patients; being disloyal to colleagues; being inadequate in the performance of work tasks and (2) troubled conscience means facing realities, with the subthemes: accepting being part of the system; responding to barriers.

Discussion: Troubled conscience meant experiencing continuous and simmering tension between one's ideals and realities and feeling a drive to preserve accountability and one's moral integrity. Endangered ideals were often under cross-pressure and included humanistic values, professional values, working life values and the values of the organisation.

Conclusion: Nurses' troubled conscience refers to a struggle, but also a force that plays out at various levels and arenas in long-term care. Openness and dialogue about how professional values and the welfare state's intentions can be realised within the given framework are important for individual nurses' occupational health as well as the quality of care provided to patients.

Keywords

stress of conscience, moral agency, nursing homes, nursing, lived experience

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Introduction

Conscience is a hallmark of humanity that spans cultures and beliefs; it is often used in everyday language with various meanings, including clear, good, unclear, troubled, guilty or bad.[1] The experience of conscience requires personal self-insight; it is primarily a belief and assessment of what would be wrong for oneself when one is in danger of deviating from standards.[2,3] Human treatment professions such as nursing often require workers to face choices that are perceived as ethically difficult and may challenge the individual's conscience. Although the frequency of ethically difficult situations seems to have increased during the global pandemic,[4–6] it has been long recognised that troubled conscience among nurses and other healthcare workers represents a significant contributor to moral distress, burnout and attrition among healthcare workers.[7,8] Still, the phenomenon has predominantly been studied in critical care and hospital environments[9] and is inadequately conceptualised and poorly understood.[8,10] Our study seeks to clarify the meaning of the phenomenon of troubled conscience in the context of long-term care, i.e. nursing homes, as experienced by registered nurses (RNs), actualised by the challenges of vulnerable patients, work intensification and sustainability in the workforce in Norway as elsewhere in the world.[11–13]

Background

Nurses describe conscience as a driving and restricting force that is also a source of sensitivity.[1,14] When it is perceived as an asset, conscience can guide nurses to provide good care, but when it is perceived as a burden, it may generate stress.[1] In this study, we lean on the perspectives of Glasberg et al.[15] who emphasise that conscience represents the core values that arise and function as different voices from ourselves, from others and the cultural context we live in and that discrepancy between the different voices causes a troubled conscience.[15] Troubled conscience is a growing and multifaceted field of research that focuses on its contributing factors and conditions, the relationship between troubled conscience and perception of conscience, its psychological and emotional consequences and the interventions that can be used to reduce stress related to conscience.[10]

What causes a troubled conscience in nurses working in nursing homes and home care services is addressed both nationally[16,17] and internationally.[15,18–21] For example, working conditions can make it difficult for nurses to follow their own consciences, avoid moral injury and provide the care they believe patients deserve.[15,17–19] Swedish studies also show that nurses' perception of conscience can influence their assessments and moral decisions, and that conflicts in the collegium can lead to nurses having to deaden their conscience, which create stress.[1,20,21] Nurses' psychological and emotional reactions to troubled conscience include powerlessness, inadequacy, guilt and burnout.[22,23] Although there is globally limited evidence for interventions that counteract troubled conscience,[10] Swedish research shows that introduction of person-centred care, stronger leadership commitment and adapted work environments have shown promising results in terms of reduced stress and improved quality of care in nursing homes.[24–26]

A recent review[8] revealed that definitions and understanding of the phenomenon of troubled conscience diverge when the emphasis alternates between external and internal constraints on moral action. Examples of external constraints can be hierarchical decision levels, insufficient financial resources and divergent expectations from colleagues and relatives.[7] Internal constraints, which includes self-doubt, socialisation to follow orders, perceived powerlessness and lack of understanding, seems to be the least explored.[8] Our perspective is that nursing is a moral social practice[27] that plays out in a working community in which internal and external factors interact. The working community of nurses in nursing homes is also compatible with what Lipsky[28] has called the welfare state's street-level bureaucrats. Nurses are expected to realise great ambitions on behalf of society and the profession, while facing ever-limited resources. According to Bernardo

Zacka,[29] the dilemma of street-level bureaucrats is that working conditions and cultural mechanisms can undermine their ability to be moral agents in exercising the discretion required and expected by society.

'Long-term care' in Norway is part of the primary health service and the municipality's responsibility, which involves services that are covered at home, in assisted living facilities or in nursing homes.[30] Despite rising numbers of older people, the number of beds in nursing homes in Norway has been reduced.[11] Conditions for obtaining a place in an institution have been tightened and patients in nursing homes are now the oldest, most frail and dependent patients.[13] While the transfer of tasks from hospitals to municipal healthcare services, such as nursing homes, is increasing, funding has not increased correspondingly.[31] In addition, services struggle to recruit and retain nurses.[11]

Compared with other countries in the Organisation for Economic Co-operation and Development (OECD), Norway has a high nursing coverage rate, but the rate of part-time working and the sick leaves has been high. In 2019, 57% of nurses worked part-time, the sick leave rate was 11% and up to 18% of all nursing positions remained vacant due to recruitment problems or long-term sick leave.[11] A 2021 survey conducted by the Norwegian Nursing Association[32] revealed that more than 70% of nurses in municipal healthcare services, including nursing homes, reported that they had considered quitting the profession, while more than 60% reported that the mental workload was decisive. These conditions, as well as the high level of stress of conscience in long-term care,[33] underline the need for deeper exploration of what the phenomenon means. To our knowledge, no Norwegian study has examined the meaning of troubled conscience among nurses in this care setting. Therefore, the aim of this study was to illuminate and interpret the meaning of the lived experience of troubled conscience among registered nurses working in nursing homes.

Method

Design

Our study design employed a phenomenological hermeneutic approach[34]; we used nurses' stories to gather concrete accounts of their lived experience of troubled conscience.[35] Through narration, we collect our experiences, we edit, we decide what is important and we make sense of our lives.[36] Narratives reveal time and context, and participants' articulation of their motivation and action in experiences of real life phenomena make it possible to uncover essential meanings that can be understood and conveyed.[35]

Participants and setting

The study was conducted from February to March of 2021 in nursing homes in three municipalities in mid-Norway. Information about the study and an invitation to participate were passed on via nursing managers, who also put the researchers in touch with nurses who expressed interest and wanted more detailed information. The first author contacted participants by phone to provide more information about the study and made appointments for the interviews. Ten nurses initially agreed to participate, but two withdrew before the interviews started, without giving any reason for this.

Eight RNs, six women and two men, from five nursing homes consented to participate in this study. All participants were ethnic Norwegian. Some of the nurses worked in different wards at the same nursing home. The wards covered dementia care, palliative care, general geriatrics and rehabilitation. Depending on the day of the week or staffing deficits, the nurses could be responsible for between seven and 66 patients. The age of the participants ranged between 29 and 54 years (md = 39.5) and they had between seven and 29 years (md = 13) of professional nursing experience. Six of the nurses worked full time and two of them worked part-time.

Three of the participants had extended education in ageing and health, rehabilitation and advanced clinical nursing. Two of the participants had previous management experience and three had administrative tasks as part of their position.

Data collection

The first author conducted the interviews and the nurses were asked to share stories about situations from their everyday work in which they had experienced troubled conscience. In order to encourage the participants to elaborate and detail their narratives as freely as possible, follow-up questions were used to clarify expressions and get more information about what the nurses thought, felt and did in the situations. The narrative strategy served not only as a tool for data collection, but also as a meeting between the parties (interviewer and interviewee) that created meaning together.[37]

Based on the participants' preferences, four of the interviews took place in conference rooms at the nursing homes and one at the university. Due to the COVID-19 pandemic, three of the interviews were conducted digitally. The interviews lasted between 48 to 68 min and they were recorded and transcribed verbatim.

Data analysis

Phenomenological hermeneutic analysis is a tool that allows an understanding of phenomena that goes beyond highlighting people's experiences to understand what these experiences mean.[34] This approach, inspired by the philosophy of Edmund Husserl and Paul Ricoeur, draws on both phenomenology and hermeneutics.[35]

In the first phase of phenomenological hermeneutic analysis,[34] *naive reading*, the interviews were read in their entirety and a first interpretation was formulated based on its meaning. In the second phase, *structural analysis*, the text was divided into units of meaning that were relevant for illuminating the study's purpose. The meaning units were then condensed into everyday language that reflected similarities and differences. We performed several structural analyses which was seen in connection with the naïve reading phase before five subthemes emerged; these, in turn, were abstracted into two themes. In the third phase, *comprehensive understanding*, we examined the naïve reading subthemes and themes in relation to illuminating lived experience with troubled conscience in its context through the researchers' preunderstanding and theoretical framework. This method allowed a dialectical movement between the different phases and between parts of the text and the whole in order to explain and understand the phenomenon in a new way.[34] Descriptions and interpretations were thoroughly discussed among the authors before agreement was reached.

To ensure the study's rigour and credibility, information about context, participants, data collection and analysis is reproduced as transparently as possible.

Ethical considerations

All of the nurses signed an informed consent form prior to the interviews based on oral and written information about the aim of the study and the procedures that were used to ensure confidentiality. The nurses were reminded of their duty of confidentiality and asked to avoid sharing detailed information about the patients, relatives or colleagues mentioned in their stories. We obtained ethical approval from the Norwegian Centre for Research Data (Project no. 571318).

Findings

Naïve reading

The nurses described troubled conscience as both a general experience in their everyday work and as an experience that stemmed from unique events they could not forget or that continued to bother them. The experience of troubled conscience could be strong or weak and of shorter or longer duration, and it involved feelings of sadness, guilt, remorse and frustration. Several of the nurses reported that their experiences of troubled conscience had changed throughout their careers and with experiences from different workplaces. Doing something wrong or not doing enough was a common feature of the nurses' experiences, and these feelings extended to patients, colleagues or tasks for which they were responsible. Troubled conscience meant an awareness of having abandoned their ideals of well-done work or good behaviour. The pain the nurses experienced in such situations drove them to want to make amends or reduce the possibility of ending up in similar situations. At the same time, they expressed a need to explain the realities and demands of the system that had narrowed their room to manoeuvre.

Structural analysis

The structural analysis resulted in two themes that contained five subthemes (Table 1).

Theme 1: Troubled conscience means abandoning ideals

Experiencing troubled conscience challenged the nurses' perceptions of their obligations. They realised that they were not able to fulfil the ideals for their work, which in practice meant failing dependent patients, being disloyal to colleagues or being unable to complete all tasks. The participants reported that this experience could be consistent as an undertone in their everyday work or arise from a specific event.

Subtheme: Failing dependent patients. The nurses' troubled consciences were focused primarily on failing frail and dependent patients. One nurse said that '*Many patients are so fragile, and we are their spokesperson… This patient is completely dependent on me communicating what I observe to get the right treatment*.' In the nurses' examples, their patients' dependence was linked to being bedridden, not demanding anything or being unable to express their care needs. The experience of repeatedly failing to care for vulnerable patients resulted in a persistent feeling of betrayal.

In other cases, troubled conscience was related to particular events that the nurses could not forget. These could include failing dying patients or not detecting a fatal disease development, or conversely, maintaining life-prolonging treatment that proves useless. One nurse in a dementia ward with a strong focus on person-centred care reported having discovered too late that a man with very restless behaviour was dying:

Table 1. Overview of themes and subthemes.

Subthemes	Themes
Failing dependent patients	Troubled conscience means abandoning ideals
Being disloyal to colleagues	
Being inadequate in the performance of work tasks	
Accepting being part of the system	Troubled conscience means facing realities
Responding to barriers	

> We did not see the big picture, that he entered a terminal phase. He walked around the ward and wanted to go home, was skinny, probably terrified and a lot was happening in his body that we did not discover. We treated his difficult behavior and his wounds ... but the man was really very sick ... if only we had thought differently, a little earlier.

The nurse reported that they had realised in retrospect that a one-sided focus had contributed to a failure to fulfil a holistic approach in the terminal phase. Other examples also referred to end-of-life care, and the nurses expressed particular concerns that no one should have to die alone. One nurse reported feeling very upset after finding a patient dead when she arrived to do their morning care: '*It was this with her dying alone, that no one was present. We were busy with other tasks nearby and the door to her room was ajar, but still*.'

For the participants, failure not only meant failing to alleviate a patient's physical ailments, but also a failure to meet their psychosocial and existential needs.

Subtheme: Being disloyal to colleagues. Troubled conscience also meant being disloyal to colleagues whom they were unable to assist as they wished. This could often happen when nurses were responsible for several departments on the same shift. One nurse stated that:

> I can have a very bad conscience if there are many nursing tasks and procedures ... I would like to help with the other tasks as well ... then I feel that ... a lot was left to the others to do today.

This could lead to an underlying feeling of unrest and disloyalty which is reinforced when colleagues directly point out that the nurse did not help, or when the nurse overhears that others did not have time to eat their lunch. Younger and less experienced nurses reported that they tried to be loyal to more experienced nurses and to the prevailing work culture in order to maintain good collegial conditions. The participants also offered examples of times that they had criticised colleagues. In these situations, they stated that they had been afraid of hurting their colleague's feelings or being perceived as a 'besserwisser'. One nurse shared that as a new employee, she had reported some of her colleagues because they had used unnecessary coercion with a patient. Despite the fact that she thought it was in the patient's best interests, she had a troubled conscience about it with regard to her colleagues: 'I felt it ... they were my colleagues, this had consequences for them. What do they think of me now? They did not greet me in the hallway afterwards.'

This example describes a conflict of loyalty and how it felt to be perceived as disloyal. Meanwhile, other examples demonstrated that with longer work experience, nurses gained more confidence in their own judgement and increased courage to communicate with colleagues about best practices.

Subtheme: Being inadequate in the performance of work tasks. For the participants, troubled conscience also meant an inability to fulfil all the work tasks for which nurses are responsible. As one nurse said, '*We were appointed to take responsibility for everything, both the patient-related work and the administrative tasks*.'

The majority of the nurses worked in large positions and said that they became well acquainted with patients at their work. In dementia wards, they were concerned with adapting the care to the patients' daily routines and mood. Several expressed that they tried to compensate for nurses who were less experienced or unknown in the ward. This led to a general sense of responsibility and that they should '*be everywhere and do everything at all times*.' Since this was not possible, they were constantly affected by pangs of conscience.

The nurses also spoke about a number of tasks they were responsible for in addition to clinical patient care. This could apply to administrative tasks such as documentation, filling in forms, ordering goods and arranging medicines, in addition to some filling a role as shop stewards without being allotted extra time. They also reported having to fill in if there was a lack of staff in homecare services. The nurses expressed that they did not have enough time and that they constantly felt torn between different tasks, which resulted in an

underlying feeling of inadequacy in their everyday work. Prioritising one thing over another made it impossible to perform their tasks as desired, and having good conscience associated with some tasks resulted in bad conscience towards other tasks. However, several of the nurses added that experience made it easier to distinguish between more and less important tasks, which also eased their conscience.

Theme 2: Troubled conscience means facing realities

Having a troubled conscience resulted in a sense of guilt and remorse and the need to explain what had gone wrong. The nurses' practice and ability to live up to ideals was often seen as dependent on collaboration with colleagues and the organisation for which they worked. Having a troubled conscience therefore meant having to deal with reality and accept that one is part of the system while also trying to influence barriers in the organisation.

Subtheme: Accepting being part of the system. The realities of everyday work had a profound impact on the nurses' troubled consciences. One example of this was the extent of the responsibility they felt was imposed. One of the nurses stated, '*I feel angry at the system – we have too many sick patients to take care of*.'

Other plausible explanations for unfortunate events reported by the participants included such realities as high care burden and variation in patient categories, unexpected incidents, lack of time and low staffing.

Implementation of higher-level decisions is also a reality that governs the service. One nurse reported that she had to inform a patient and his relatives that he was to be discharged from the nursing home and respond to their negative reactions. The decision went against her own assessment of the patient's needs and the fact that she had previously promised the relatives more time to prepare for a good transition to the home. She had to accept the decision, but in dialogue with relatives, she openly expressed that she did not agree with the assessment made by the allocation office: '*To the relatives, I said:* "*I fully understand that this did not turn out as you expected and not as I expected, but we must try to make the best of it.*"'

Subtheme: Responding to barriers. Troubled conscience also meant an urge among the nurses to compensate for the times they felt they had failed their patients. The participants conveyed motivation to take advantage of opportunities to create golden moments that could offset what the nurses experienced as a general shortage situation:

> We decided to watch a TV show that evening. We turned up the volume, had something good in the glass and had a dance night. We wheeled one of the bedridden patients into the living room and it was so wonderful, because we saw the whole patient how he lit up.

Troubled conscience could also be a driving force in influencing more structural routines and conditions. This could apply to the purchase of equipment or changes in routines such as arranging for personnel to be assigned to stay by the bed of a dying person. As one of the nurses said, '*I feel that it* (troubled conscience) *may have affected me a little positively as well, that I have become a driving force so that no one will have to die alone*.'

Other attempts to overcome barriers revolved around prioritising tasks among colleagues. In particular, this involved the prioritisation of patient-oriented work versus task-oriented work (i.e. routine work that was expected to be carried out on the individual shift). One nurse explained that the staff group discussed and agreed upon how to prioritise and that this had positive consequences for their collaboration:

> If we have not succeeded in carrying out full morning care or are late with something, then it will not be met with disapproval from the staff who come on the next shift.

The same participant believed that each individual had a responsibility to speak up when the work compromised their own values. Such challenges should be discussed among colleagues and things could be solved for the good of both patients and carers.

Comprehensive understanding

Troubled conscience among nurses in nursing homes meant abandoning one's ideals for work towards patients, colleagues and tasks they were responsible for. This involved an assessment of practice about something right – an ideal or standard that the nurses wanted to work towards that comprised humanistic, professional and working life values. Their perceptions of role and responsibility also had an impact on the meaning of troubled conscience.

The nurses felt responsibility for mistakes that had been made; however, structural barriers made it difficult to realise the ideals they had for their work. Barriers such as lack of time, staffing, competence and adequate service level were the underlying causes of troubled conscience; these barriers presented explanations for mistakes. Nevertheless, the nurses had to deal with reality for themselves, their patients, and the patients' relatives. However, expressing one's opinion, seizing opportunities that arose and influencing structural constraints contributed to experiences of accountability and integrity.

Discussion

Our study adds new knowledge about what a troubled conscience means for registered nurses who work in Norwegian nursing homes. Our interpretation of the nurses' stories revealed that troubled conscience meant being in a continuous and simmering tension between ideals and realities and sensing a drive to preserve accountability and one's own moral integrity. The endangered ideals were often under cross-pressure and included humanistic and professional values and the values of working life and the organisation. In line with previous research, we found that a troubled conscience was often related to external conditions that made it difficult or impossible to meet one's own or others' expectations of good practice.[16–19] However, we also found a significant interplay between external and internal factors in terms of causes of concern, degrees of troubled conscience and what it meant for the nurses' actions and coping. For example, more experienced nurses said that they had developed increased confidence in their own judgement and courage to disagree with colleagues. Other examples showed that while inner recognition of external constraints such as lack of resources or demands to effect the decisions of others sometimes created feelings of anger and powerlessness; at times this resulted in more rational adjustments to make the best of the work, whether individually or collectively. Elements of such adaptations are consistent with previous findings[20,21] demonstrating that nurses sometimes have to deaden their conscience. Moreover, our findings revealed that mechanisms in the collaboration and communication between the nurses in the ward influenced their experience of troubled conscience. This is in line with the perspectives of Peter and Liaschenko,[27] who regard stressed conscience as a response to constraints on nurses' moral identities, responsibilities and relationships rather than a response to specific external causes. They[27] argue that it is institutions rather than discrete actions that create constraints on nurses' moral identities and hinder their ability to function as autonomous moral agents and to act in accordance with their core values and professional responsibilities.

The nurses reported that they often found themselves in impossible situations with almost limitless expectations where they were aware of the right thing to do but were unable to do it, which coincides with the experiences of what Lipsky[28] calls street-level bureaucrats. Street-level bureaucrats' understanding of their roles and responsibilities is shaped by the environment in which they operate – especially their moral agency.[29] Zacka[29] points out that employees in welfare states are exposed to 'a plurality of normative demands that frequently points in competing directions; they must be efficient in the use of public resources,

fair in dealing with clients, responsive towards their needs, and respectful when interacting with them'.[29] Such requirements would be challenging in any context, but nurses who work in nursing homes must perform them under exceptionally demanding working conditions. On any given day, they must deal with mismatches between tasks and resources,[38] a lack of employees with the right skills[39] and incompatible and unrealistic goals[40] while continuing to engage in emotionally trying meetings with people who are in vulnerable situations.

Traditionally, a nurse's moral obligation is directed primarily at the patient, resulting in high expectations for the quality of the nurse–patient relationship and for the individual nurse's moral integrity.[27] Our findings confirm that while the nurses maintained their strong commitments to their patients, they also felt strong commitment to their colleagues and work tasks, and hence, a commitment to the organisation they worked for and to society. The nurses' stories concretised such ideals as dignity and person-centred care in encounters with individual patients and such universal values as justice in the distribution of services in the welfare state[41] and fairness in how workloads should be allocated between staff members.[42] According to Zacka,[29] plurality in norms and values is not the problem. Instead, it is organisations that, through narrow frameworks and resources, undermine employees' moral freedom of action and their use of discretion. The result may be that neither societal nor professional ideals are possible to realise.[41] The gap between intent and reality becomes real for the nurses in our study who talk about not being present when a patient dies or who is unable to meet the needs of a helpless patient. Being the face of a failing health service appeared to be a private defeat for the nurses we interviewed, but the conscience also showed itself as an asset[1,14] through attempts to repair damage and avoid new injuries.

When troubled conscience meant facing realities, this appeared in two ways in our findings. In one way, it led to the nurses adapting by accepting inadequacies, sometimes by narrowing the understanding of requirements so that they could be met in other ways – for example, by agreeing with colleagues that the time allotted for morning care could be extended. Troubled conscience also led the nurses to compensate for failure by applying extra effort towards particularly vulnerable patients or taking initiative to change routines, such as hiring extra staff for dying patients.

The example illustrating how nurses had jointly discussed challenges and agreed that personal care should override tasks suggests that moral practice is developed through social processes.[27] Beyond being just a source of suffering for nurses, troubled conscience can thus mobilise ethical discussions and open dialogue and self-reflection within a healthcare team. Street-level bureaucrats may thus influence both structural conditions and each other in terms of the way the work should be performed. To prevent moral distress, Zacka[29] suggests orchestrating an environment in which street-level bureaucrats develop self-understanding and exercise discretion. Such an environment will also invite to shed light on cultural differences in the perception of conscience, which reflect one's upbringing and religious or social conventions[43] and which require constant reflection and awareness of the prevailing values.[29]

The theory of street-level bureaucrats is rarely used in nursing research, but it provides a useful analytical framework for contextualising and understanding phenomena in nurses' everyday work. We recommend that future studies pursue the evidence that reveals that moral questions and concerns do not pertain solely to individuals, but also to social communities and organisations.

This study was conducted in a limited geographical area with a limited number of participants. Another limitation of the study is that due to the COVID-19 pandemic, some of the interviews could not be conducted face-to-face. However, the nurses had extensive professional experience and rich stories relating to the phenomenon being studied. Our findings coincided with and could be illuminated by previous studies and theories in the field. The analysis allowed us to describe explanations and interpretations[34] in a transparent way to reflect the accuracy of our findings. The authors, all of whom are nurses with experience in both municipal long-term care and hospitals, benefited from examining and discussing their own preconceptions. We conducted the analysis through repeated discussions among the authors; the findings must be considered

one of several possible interpretations[44] that can enrich the debate about the phenomenon of troubled conscience.

More studies examining the lived experience of troubled conscience when working in long-term care settings are needed. Not least, this applies to the inclusion of nurses from different cultural backgrounds, which is increasingly relevant with greater migration and an increasing proportion of nurses from multicultural backgrounds.[45] The present study only reflects ethnic Norwegian nurses.

Conclusion

The nurse's troubled conscience refers to a struggle, but also a force that unfolds at different levels and arenas in long-term care. We propose that nurses in nursing homes should be given the opportunity to express and discuss perceived discrepancies between different values that create a troubled conscience. Openness and dialogue about how professional values and the welfare state's intentions can be realised within the given framework are important for individual nurses' occupational health as well as the quality of care provided to patients.

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