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Gerd Sylvi Sellevold
Lovisenberg diakonale høgskole

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Quality dementia care – Prerequisites and relational ethics among multicultural healthcare providers.

Gerd Sylvi Sellevold[1]
Veslemøy Egede- Nissen[2], Rita Jakobsen[1] and Venke Sørlie[1]

[1]Lovisenberg Diaconal University College, Norway
[2]Oslo and Akershus University Collage, Norway

Corresponding author:
Gerd Sylvi Sellevold, Lovisenberg Diaconal University College, Lovisenberggata 15 B, Oslo 0456, Norway
Email: Gerd.Sylvi.Sellevold@ldh.no

Abstract

Background: Many nursing homes are multicultural workplaces where the majority of healthcare providers have an ethnic minority background. This environment creates challenges linked to communication, interaction and cultural differences. Further, the healthcare providers have varied experiences and understanding of what quality care of patients with dementia involves.

Purpose: The aim of this study is to illuminate multi-ethnic healthcare providers´ lived experiences of their own working relationship, and its importance to quality care for people with dementia.

Research design: The study is part of a greater participatory action research (PAR) project: "Hospice values in the care for persons with dementia". The data material consists of extensive notes from seminars, project meetings and dialogue-based teaching. The text material was subjected to phenomenological-hermeneutical interpretation.

Participants and research context: Participants in the project were healthcare providers working in a nursing home unit. The participants, came from 15 different countries, had different formal qualifications, varied backgrounds and ethnic origins.

Ethical considerations: The study is approved by the Norwegian Regional Ethics Committee (REK) and the Norwegian Social Science Data Services (NSD).

Findings: The results show that good working relationships, characterized by understanding each other's vulnerability and willingness to learn from each other through shared experiences are prerequisites for quality care. The healthcare providers further described ethical challenges as uncertainty and different understandings.

Discussion: The results are discussed in the light of Lögstrup's relational philosophy of ethics and the concepts of vulnerability, ethic responsibility, trust and openness of speech.

Conclusion: The prerequisite for quality care for persons with dementia in a multicultural working environment is to create arenas for open discussions between the healthcare providers. Leadership is of great importance.

Keywords
Multicultural healthcare providers, lived experience, prerequisites, quality dementia care, relational ethics, phenomenological-hermeneutical method.

Introduction

In the years ahead there will be an increasing demand globally for competent healthcare providers in the care for persons with dementia. Due to the higher life expectancy of the population, more and more people are living with dementia.[1] According to the WHO[1] approximately 35.6 million people were afflicted in 2011, and prognoses predict that this number will double every 20 years.

Dementia is a progressive illness, and persons with dementia will gradually need care night and day. Healthcare costs for a growing ageing group of patients with dementia are already high on a global basis and will continue to increase in the time ahead.[1] Recruitment of sufficiently competent healthcare personnel is an increasing challenge worldwide,[1] as is also the case in Norway.[2] As in the rest of the western world[3-6], a large number of employees in the care of the elderly in Norway have a minority background.[7-8] This raises challenges like language and communication barriers and cultural differences between the healthcare providers[1,3]. They also have varied professional experience and understanding of what constitutes quality care for persons with dementia.[3,9]

Recent studies have brought to light various professional and ethical challenges related to quality dementia care in nursing homes, as for instance, resident and spouse involvement in decision-making, restraint, inability to meet individual needs, lack of resources and quality of person-centred care.[10] This study is part of a comprehensive investigation "Hospice values in the care for persons with dementia". The results from previous part studies are publicized in Nursing Ethics.[11] The results also show the relational ethics' importance in quality care for persons with dementia. Egede-Nissen et al.[12] found that healthcare providers experienced quality care situations when the time culture was flexible, without clock time as a stress factor. In such situations, the healthcare providers found calm to discuss professional challenges and to succeed in meeting the patients' various time experiences and needs. The results from Sellevold et al.[13] show that a prerequisite for quality care is to recognize the patient as a unique person and sense and understand the patient's bodily expression when verbal language has disappeared in the late stages of dementia. This approach in meeting the patient contributed to reciprocity in the relationship between the healthcare provider and the patient. In a later study, Egede-Nissen et al.[9] describe minority healthcare providers striving to understand quality care in their relationship with patients with dementia living in a nursing home. Studies show that minority health care providers in nursing homes are vulnerable groups experiencing communicative and cultural challenges,[3,6,14] outsideness,[14] lack of recognition and acknowledgement,[15] conflicting professional values and roles[6, 14] and discrimination[3, 6, 14, 15] in relation to work colleagues. Results from resent studies show that a working relationship characterized by openness and safety is of great importance for quality care in nursing homes.[16,17,18,19] One of the studies clarifies that the participants have different ethnic background, but do not disclose whether any of them are immigrants.[18]

The aim of the study

The aim of this study is to highlight multi-ethnic healthcare providers´ lived experiences of their own working relationship, and its importance to quality care for persons with dementia.

Methods

Design

This study is part of a larger participatory action research (PAR) project with a duration

of five years: “Hospice values in the care for persons with dementia”. This study was conducted using Lindseth and Norberg's[20] qualitative phenomenological-hermeneutical approach suitable for shedding light on lived experience, inspired by the French philosopher Paul Ricoeur.[21]

Participants

A total of 25 multi-ethnic healthcare providers employed at the nursing home unit participated in the study. The participants came from 15 different countries and cultures, including Scandinavia, southern Europe, Asia, Africa and south America. They had different formal qualifications (registered nurses, state enrolled nurses and nursing assistants).

Ethical considerations

The study is approved by The Norwegian Regional Ethics Committee (REK) and the Norwegian Social Science Data Services (NSD). An informed and formal contact about the study was conducted with the managers of the nursing home. They gave their permission to the implementation of the study, informed all the employees at one unit and requested their participation. The authors and the managers attended to several meetings where information and questions about the study was shared. All employees gave their consent to participate in the study. The data material is anonymized.

Data collection

Within PAR importance is attached to disclosing subjective and local experiential knowledge which again gets an essential role in developing clinical practice and new knowledge.[22,23,24] The data material was collected by the authors and consists of extensive notes from group meetings and discussions in seminars, project meetings and dialogue-based lectures. Here personnel and the researchers alike were challenged to reflect on what characterized, as well as what challenged, quality care for patients with dementia.

The key question throughout the intervention phase was about their experiences with performing quality care for persons with dementia. The central question in this study concerned their experiences with their own working relationship and its importance for quality care.

Data analysis

The analysis process constitutes a dialectic movement between the whole and the parts of the text and the understanding and explanation, and the researcher moves between the three phases: *Naive reading, Structural analysis and Comprehensive understanding.*[15]

Naive reading. After reading the text several times to get an impression of what the text was about,[20,21] the importance of a good working relationship emerged. A good working relationship seemed to be a prerequisite for quality care.

Structural analyses. In explaining the text's meaning, data was divided into units of meaning, where sentences, parts of sentences or paragraphs represented one meaning. These were then reflected on in the light of the naïve understanding. The themes revealed by the structural analysis, "prerequisites for quality care" and "ethical challenges", as well as direct quotations from the text are presented in "Findings".

Comprehensive understanding. The final stage of the analysis is a critical interpretation aimed at a comprehensive understanding of the text's meaning. The authors developed an in depth interpretation based on their pre-understanding, the naive reading, the structural analysis and relevant literature, and constitutes this article's discussion section.[14,15] The purpose of this interpretation phase was to contribute to new knowledge through a new understanding of the meaning of how healthcare providers experience their working relationship and its impact on quality care. The text's meaning may be interpreted in different ways[20] and our critical interpretation is one way of understanding the text's meaning.[21]

Results

The two themes, each with sub-themes, revealed by the data, are summarized in Table 1.

Table 1. Themes and subthemes revealed by the structural analyses

Themes	Sub-themes
Prerequisites for quality care	To meet each other's vulnerability To learn from each other
Relational ethical challenges	To be uncertain

	To have a different understanding

Prerequisites for quality care

To meet each other's vulnerability. The healthcare providers expressed that good cooperation between themselves was an important precondition for quality care for patients with dementia and that a good relationship between themselves led to quality care for the patients. "*How we as healthcare providers talk together filters through to the patient. The respect we show when we instruct one another filters through to the patient.*" The healthcare providers reflected on how they behaved themselves in meeting one another. "*We must have a self-awareness about our behaviour and reactions*." They reported that it was important to be open and patient in their meeting with each other to create a sense of security and "*to be patient and not to scare away*." Also of importance was politeness and "*to show sensitivity and be careful*" towards each other to get better acquainted. They acknowledged that openness and patience were qualities necessary to develop further through common reflection and a central theme was "*how you communicate and behave when showing respect and care for one another*".

In particular, the healthcare providers emphasized that giving each other enough time was an essential prerequisite for quality care for patients with dementia. To give the other time could, for instance, be to give colleagues struggling with the Norwegian language sufficient time to make themselves understood and to understand. It was also about taking time to get to know each other's' competence and to get to know each other as individuals and as professionals. "*We must give each other enough time to show what we can do and who we are*." They reflected on the moral consequences of not giving colleagues enough time to develop and make their competence visible. "*The new ones need time, not pressure; it is unethical to prevent them from growing to their potential*." In their meeting with new colleagues, it was important to create assurance through ample time to give precise information so that they got acquainted with existing practices and frameworks, and also to give sufficient time to listen to and to answer the new colleague's questions. It was also important in meeting colleagues with a minority language background to adjust communication accordingly. "*In the beginning, you have to form short sentences and give the healthcare provider time to understand*."

In their meeting with new colleagues, the healthcare providers maintained that it was necessary to give clear feedback and to signal when the work was not performed according to professional norms. "*Give each other both criticism and praise*" which had to be done in a polite and considerate way, and the healthcare providers reflected on their way of guiding colleagues. They were concerned with the way they could point out to each other that their work was not in line with professional and/or the unit's norms for quality care and to do this in a way that contributed to learning. "*I wonder how I can tell the other that she makes mistakes and explain it in a way that creates understanding and change?*" Guidance of colleagues also meant encouraging the other to speak up and helping the other to set limits concerning complexity and extent of work tasks. "*It might be necessary to help each other to impose limits*."

According to the healthcare providers, openness for each other's cultures, and willingness to learn about each other's cultures, were prerequisites for a good working relationship distinguished by mutual respect and understanding for each other and each other's' cultural background. "*To learn about others' cultures; we must open up to other cultures*." The healthcare providers explained how culture could influence how care was practiced. Respect for the other's cultural background meant that cultural nuances in the performance of tasks were accepted as long as it was not contrary to professional and ethical norms for quality care. "*Habits from other cultures must not be unlearnt; rather we must understand and accept each other's habits*." Respect also entails that an understanding of cultural expressions could be a positive contribution. "*We are different, we are unique, each in our way."* Being open to cultural differences was not just a prerequisite for a good working relationship, but also a prerequisite for quality care.

To learn from each other. The healthcare providers told that openness and honesty in the relationship between colleagues and the unit's head were important to experiencing trust in oneself as well as in each other, and thereby a prerequisite for quality care. Openness meant talking together and getting acquainted with each other's understanding and meanings. "*We should not be afraid of bringing up an issue in our daily work*" The conversation could have a varied form and diverse themes, for instance organization and cooperation. "*To agree on who has the responsibility for what. Cooperate and prioritize*." Other conversations were related to patient situations. "*Discuss there and then when something acute happens in a particular situation*."
The conversations could also aim at progress. "*Sit down and talk about what works and what does not*." Through these discussions, they also described how they developed their professional confidence. "*The more you talk together, the more you have the experience of not being alone in thinking like this*." They also got to know each other and trust each other as persons and professionals. "*Confidence, count on each other*

and rely on each other."

The healthcare providers stressed that having a working community where they could learn from each other was an important prerequisite for quality care. To talk together about situations where they experienced giving quality care and sharing knowledge with each other, was necessary for their mutual professional development. "*To develop quality care is to use the time to talk together about what is worthwhile and about the challenges met in achieving quality care. Good attitudes spread*."

They reflected on how they experienced themselves in their meetings with others and how the others experienced them. "*How do we make each other aware of how I am seen by the other*?" To cooperate gives possibilities to learn from each other. "*To work together when caring for the patient*" and "*be role models for each other and guide each other*." The healthcare providers reported that colleagues had varied backgrounds and that it was, therefore, important "*to draw from each other's' competence*."

The healthcare providers claimed that a prerequisite for quality care was to create various arenas for learning. "*Professional and social gatherings where the theme is everyday challenges and reflections on these*." Daily common reports and group reports were also important arenas where they could reflect on professional and ethical challenges in meeting the patient.

The healthcare providers experienced that they developed a mutual understanding that openness about their individual professional, language and cultural uncertainty was a prerequisite for quality care. "*It is important to be open about what you can and what you cannot*." The healthcare providers emphasized the importance of the obligation to speak up when the work tasks were perceived as challenging and uncomfortable, or one did not understand the situation and what was said. They also maintained that it was a common responsibility to develop a work community where it was legitimate to ask when being uncertain, and where it was room for discussion about situations where one experienced professional uncertainty. "*One has to open up for a discussion if one is uncertain about what to do*."

Relational-ethical challenges

To be uncertain. The healthcare providers described how they experienced vulnerability in their relation to colleagues in various ways. They told how their vulnerability was often jeopardized in ethically challenging situations where they experienced not succeeding in giving quality care for patients with dementia and that they were afraid of embarrassing themselves. They, therefore omitted discussing such situations with

colleagues. "*I get a feeling of having done a bad job*." They described how they did not dare to set limits or ask when they were uncertain. "*I don't dare to talk about what feels uncertain or speak up when the responsibility feels uncomfortable*." "*I get frightened when I get more responsibility than I can cope with*." They reported this as negative for their professional self-confidence. "*I may be afraid of not mastering the situation because I´m not sufficiently experienced*." The healthcare providers also described situations with "*professional disagreement*" where they felt inadequacy. The healthcare providers expressed that they often felt alone in situations with several additional staff on duty. "*It wears you out to work with many new additional staff who do not see the whole picture*."

Healthcare providers with a minority language background described that speaking Norwegian was a great challenge and a source of insecurity. "*The greatest challenge when I came here was the language, not to be understood and not understanding others*". The care providers experienced having insufficient vocabulary which could also create misunderstandings and disagreements. "*I become afraid to use words when I am uncertain about the language and may be too scarce and direct*."

Healthcare providers with a minority background said that they were afraid of revealing professional, language and cultural uncertainty in their meeting with colleagues and this made them passive in professional conversations and discussions. "I *experience being vulnerable in a new job in a new country where my potential is not seen*". The lack of professional openness made it difficult for the healthcare providers to trust each other because they did not get the opportunity to get acquainted with each other's competence. *"We do not get to know each other's competence when we keep quiet"*.

To have a different understanding. The healthcare providers said that varied cultural awareness could be demanding and contribute to distance and conflicts among the healthcare providers. The healthcare providers could, for instance, with their varied cultural background have different views on elderly people and a different understanding of the concept of respect in their meeting with the patient. "*In my culture the elderly have status; what they say is respected. Here I may experience that some treat the elderly as if they do not have anything to say*." Healthcare providers with a minority background told that they were used to less openness and were unaccustomed with expressing professional views to colleagues with a higher status than themselves, as for instance to healthcare providers and managers. Neither did they manage to convey their thoughts and meanings in such situations, nor they did manage to argue for what they considered to be quality care. They were, therefore, afraid that colleagues should see them as incompetent. "*In our culture, we are not supposed to say what we*

think, particularly not to people above us in status."

Discussion

Discussion on results

Our results show that openness in the encounter with each other´s vulnerability and to learn from each other are prerequisites for quality care for patients with dementia. At the same time, the results show that the healthcare providers experience relational ethical challenges which may endanger quality care. To handle these relational ethical challenges is, therefore, a prerequisite for quality care.

The results show that the healthcare providers experienced vulnerability in their working relationship in various situations where their own practice of quality care was exposed, and they were afraid of revealing their vulnerability. We are as persons mutually dependent on each other.[25] Dependence, vulnerability, and fragility are three characterizations of being a human being. As human beings, we all are vulnerable and left to and dependent on other´s care. This vulnerability implies a risk of not being seen or accepted by those we are dependent upon, which makes us even more vulnerable and fragile.[26]

The spontaneous life expressions: trust, openness, genuineness, faithfulness, compassion and love are characteristics that fulfil our lives and which are fundamental to our existence.[25] According to Løgstrup,[25] to encounter each other with trust from the outset is a natural and spontaneous part of being a human being. Trust is an utterance of life, and a phenomenon with life itself. Trust emerges in human relations. No one can create trust. Trust must be achieved through action and behaviour. [25,27] To show each other trust means, at the same time, to expose oneself and put oneself in a vulnerable situation where one is at the mercy of the other. Not to accept the other´s exposure is a misuse of trust, which may lead to distrust and communication between people ceases. When healthcare providers do not choose openness and choose not to show their vulnerability towards colleagues, this may be understood as having a lack of trust that their colleagues might accept their vulnerability. The consequence may be that the healthcare providers take responsibility for tasks of which they do not see the extent, or for which they do not have the adequate competence, and in this way endanger quality care.

The results of our study show a lack of trust and openness towards each other that prevents the healthcare providers in acknowledging each other as fellow human beings

and professionals. This puts them in a vulnerable situation. Our person and our self is formed and exists through our relations with others. We are a person by virtue of being in the centre of and being confirmed by another person's attention.[26] The good for a person is to realize the possibilities they have by virtue of their potential.[28] According to Løgstrup[27], speech is in itself a request for openness, and we realize or fulfil ourselves by speaking openly in our encounters with others. The ethical challenge implies accepting and meeting what is at stake in the other's life.[25] It is reasonable to assume that not being approved as a fellow human being and a professional person may jeopardize healthcare providers' lives. According to Jakobsen and Sørlie[29], a lack of understanding from colleagues creates a feeling of powerlessness that leads to negative health-related consequences. Absent professional authority and participation in discussions related to professional and ethical decisions are factors contributing to moral stress in healthcare personnel.[30] Moral stress may lead to physical and psychological stress in healthcare providers. Diminished work satisfaction and poorer patient care make healthcare providers less empathetic, or they withdraw from relationships with colleague and patients.[30,31,32] Openness may be understood as an ethical matter and an important prerequisite for quality care practice. Egede-Nissen et al.'s[12] study shows that to take the time necessary to talk together about various professional and ethical challenges is an important sign of quality care, and is confirmed in this study.

The healthcare providers had a wide range of cultural backgrounds and varied conceptions of what constitutes quality care for patients with dementia. Earlier in this text its referred to challenges related to language, communication barriers, cultural differences and conflicting professional values and roles between multi-ethnic health care providers.[3,6,14] According to MacIntyre[33] what we understand as good is connected to the culture we belong to and to the values on which this culture is based. Christensen[28] refers to the abilities we employ to do the right thing in situations, also in work situations, as virtues. The important virtues are courage, righteousness, temperance and wisdom, with the last as the most important moral virtue.[26] MacIntyre[33] claims that virtue is learned within a working community, and it is, in the development of practice, necessary to clarify which virtues are important and to support these. The results show that a prerequisite for quality care is that the healthcare providers with different cultural backgrounds are all open and take the time to discuss professional and ethical challenges and discuss what constitutes quality care for persons with dementia in various situations. Virtues are thus exhibited that are essential for quality care. The healthcare providers learn from each other and get the possibility to further develop their own and each other's understanding of what quality care is for patients with dementia. Our results correspond with previous research showing that an open and safe working relationship is of great importance for quality care in nursing homes.[16,17,18,19]

This is also in line with Martinsen[34] who claims that reflective conversations, where one listens to each other and reply with new questions, contribute to greater understanding and courage. Such discussions need time and space.

The results show that the healthcare providers developed greater confidence in revealing their vulnerability when their potential was overlooked, and they therefore reflected on the moral consequences of not giving their colleagues enough time to show their competence and to realize themselves through professional and personal development. According to Løgstrup,[25] exposure to another is a mutual phenomenon and represents a basic ethical phenomenon. Our body has a sentient attention directed towards the other, and we are bodily affected when the other through his expression make an impact on us. The impression by way of bodily reaction to the others' expressions, is fundamental in our actions towards the other.[35] Lindseth[36] says that the others' situation must affect us, and we must take in what the other needs in order to act responsibly. There is reason to believe that a prerequisite for quality care for patients with dementia is that the healthcare providers are present in the encounter with each other, where they expose themselves and also are accepted by the other. This is in line with the results found by Jacobsen's[37] study which show that quality nursing care, where the healthcare providers draw support from each other through discussing and handling professional challenges together, is significant for quality care for persons with dementia.

The results show that the healthcare providers developed trust and openness to each other when they exchanged professional views and shared experiences linked to own vulnerability. This can be understood as if they accept the ethical challenge of meeting each other's trusting disclosure of their own vulnerability and what was at stake in their everyday work.[25] According to Løgstrup,[27] sovereign expressions of life are aroused when a person is hindered in fulfilling his or her life. It is reasonable to assume that the healthcare providers' trusting revelation of what is at stake may arouse life expressions with colleagues who thereby accept them so that they may realize themselves as persons and professionals. There is reason to believe that life expressions represent prerequisites for quality care for patients with dementia.
According to Polkinghorne[38], the human being can, through reflection, experience his or her existence as a whole of the past, present and future, where experiences from the past and the present may create an understanding that contributes to creating the future. In line with MacIntyre[33] and Polkinghorne[39] the healthcare providers emphasized the creation of different arenas for reflection and dialogue where the aim was to uncover and develop common values which were seen as important for quality care practice for patients with dementia within a multi-cultural work community.[20] By being a human being, there is an openness and receptiveness to let one self be affected by others, and it is relationships between persons that create zest for life and courage to live.[35]

Relationship developed between the healthcare providers of openness and receptiveness for letting oneself be affected by each other's professional and ethical challenges. It is reasonable to assume that this created courage in the healthcare providers to discuss professional and ethical challenges with each other and to learn from each other what quality care is for patients with dementia.

Methodological consideration/Study limitations

The aim of this study was to bring to light multi–ethnic healthcare providers' lived experiences of their working relationship, and its importance to quality care for persons with dementia. In different fora, the multi – ethnic healthcare providers were challenged to reflect on, and to narrate, their experiences with how their working relationship impacted quality care. In this way past met present and the understanding created in this meeting made it possible to influence the future through the participants' learning and further development of quality care for patients with dementia.[20,38]

According to Ricoeur,[21] language may be understood both as a system (signs, words and sentences) and incidents (narrative). He calls the use of language "discourse". The text is any written discourse that may be freed from the original situation and contribute to developing a mutual understanding independent of physical presence. [21] The text represents written discourses about how the healthcare providers experienced their working relationship and its importance to quality care. Lindseth and Nordberg[20] employ a phenomenological hermeneutical method in analysing transcribed text from qualitative interviews but assert that there are many different kinds of text. As is the case with a text from qualitative interviews, a phenomenological hermeneutical analysis of this text may contribute to a new understanding of the meaning of the multi-cutural healthcare providers' narratives about their experiences with quality care.

The reliability was ensured by posing open questions to the participants about their experiences with the prerequisites and challenges with quality care seen in the light of the relation-ethical perspective. They chose different kinds of situations for their narratives depending upon their life experiences and professional perspectives. This enables us to get an in-depth insight into the phenomena. In this way, the strength and representativeness with regards to transferability are maintained. It can therefore be stated that qualitative projects show a high content of validity, which means that there is a high degree of detail in the data. Due to the lack of numerical representativeness, it is not possible to make inferences about the relative or absolute incidence of the observed phenomena in the background population.[39] This study has been conducted within a Norwegian nursing home with Norwegian framing factors. A similar study conducted within other contexts and cultures can give other results.

Conclusions and implications for care practice

The aim of this study has been to draw attention to multi–ethnic healthcare providers lived experiences with their working relationship and its impact on quality care for persons with dementia. Quality care for persons with dementia is an ethical concern about caring for the dependent and vulnerable. The results and the discussion indicate that quality care also is a relational ethical concern about their professional carers' vulnerability and their need to be accepted by each other as persons and professionals. There is reason to believe that a prerequisite for quality care for persons with dementia within a multicultural working community is to create arenas which give space and time for open conversations where the healthcare providers openly may discuss experiences linked to professional and ethical possibilities and challenges. An important leadership responsibility in this regard, is to organize and initiate.

Conflict of interest

The authors declare that there is no conflict of interest.

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