ORIGINAL RESEARCH

Structure of difficulties novice nurses encounter in providing care for older patients with dementia in acute care settings

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ABSTRACT

Background and objective: Hospitalized older patients with dementia frequently face unmet needs and adverse outcomes, creating major challenges for nurses. For novice nurses, dementia care has become an unavoidable responsibility, yet they remain especially vulnerable during their transition to practice. Previous studies have described individual difficulties, but little is known about how these difficulties interact. This study aimed to clarify the structure of difficulties experienced by novice nurses during their first year of dementia care in acute care settings, to inform supportive interventions.
Methods: A qualitative descriptive study was conducted using semi-structured interviews and a demographic survey with 11 novice nurses from five acute care hospitals in the Kanto region of Japan. Data collected between July and August 2022 were analyzed using the KJ method (affinity diagramming) to visualize the interaction structure of the challenges.
Results: Seven final labels and an affinity diagram depicting their relationships were identified. Persistent difficulties stemmed from the interplay of inexperience, the acute care environment, and dementia-related complexities. These were underpinned by ethical dilemmas and resulted in feelings of inadequacy and guilt, contributing to sustained distress throughout the year.
Conclusions: This study presents the first visual model of interrelated challenges faced by novice nurses in dementia care, offering new insights into their early clinical experience. The findings underscore the need for structured, multidimensional, and transition-sensitive educational strategies, with practical implications for nursing education and policy internationally.

Key Words: Acute care, Care difficulties, Novice nurses, Older patients with dementia

1. INTRODUCTION

By 2050, more than 150 million people will live with dementia globally. In Japan, prevalence is projected to exceed 25% by 2045.[1,2] Individuals with dementia are hospitalized more frequently than those without the condition, a trend that has been consistently associated with older age,[3] often leading to adverse outcomes, including prolonged stays, higher mortality rates, and institutionalization.[4–6]

Acute care hospitals pose significant challenges for people with dementia. These environments often fail to meet their physical, psychosocial, and autonomy-related needs due to communication difficulties and disruptive settings.[7–9] In response, behavioral and psychological symptoms of dementia (BPSD) frequently emerge, affecting approximately 75% of older patients with dementia.[8,10,11] Nevertheless, the primary focus in acute care remains on somatic issues, often

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marginalizing dementia care.[12,13]

The person-centered care (PCC) model, which emphasizes respect for the individual and their autonomy, has shown benefits for both patients and caregivers, including reductions in BPSD and caregiver burden.[14,15] Despite growing international support for implementing PCC in acute settings, its practical application is frequently hindered by systemic barriers such as hospital culture, environmental constraints, and staff knowledge gaps.[16,17]

Nurses hold a central position in dementia care, with their role becoming particularly vital within acute care settings. However, in practice, they frequently encounter complex care demands, ethical dilemmas, and considerable emotional and time burdens, all of which contribute to a heightened risk of burnout.[18–20] These challenges highlight the need for targeted support grounded in dementia nursing competencies, such as those outlined by Yamaguchi et al.[21]

In 2016, the Japanese government introduced a financial incentive scheme to improve dementia care by promoting specialized teams, enhancing staff education, and reducing physical restraint use.[22] Yet restraint reduction has been modest, frontline challenges remain unresolved,[23] and little is known about the preparedness of novice nurses—raising concerns about whether system-level reforms sufficiently address the realities of early-career practice.

Prior research has largely centered on mid-career nurses and other healthcare professionals, identifying challenges such as high physical and emotional demands, limited confidence, and ethical conflicts.[13,18] Consequently, most existing educational interventions target mid-level staff and have been shown to enhance confidence, knowledge, and self-efficacy.[24–26] In contrast, novice nurses face a steep learning curve as they develop clinical competence and adapt to professional environments—a process often accompanied by "transition shock", which involves emotional, physical, social, and intellectual challenges.[27–29] This shock negatively affects job satisfaction, stress levels, and care quality.[30] Although dementia education programs for pre-registration nurses improve knowledge, attitudes, and confidence, their long-term impact remains unclear.[31] Moreover, nursing students also report experiencing distress during dementia care placements,[32,33] suggesting that acute dementia care may exacerbate transition shock.

Although an Australian study acknowledged that dementia care is particularly difficult for novice nurses, it lacked detail.[34] A Canadian study identified specific emotional and cognitive difficulties—such as anxiety, frustration, and heightened vigilance—but did not examine how these challenges are interrelated. Notably, participants in that study had an average of 5.4 months of experience.[35]

To address this gap, the present study provides the first comprehensive account of how difficulties in dementia care are interconnected and evolve across novice nurses' first year of practice. These findings offer foundational evidence for designing early-career training that bridges classroom preparation with the realities of acute dementia care and supports workforce policies to strengthen dementia care readiness. Therefore, the objective of this study was to clarify the structure of difficulties experienced by novice nurses during their first year of dementia care in acute care settings, using the KJ method, to inform supportive interventions.

2. METHODS

2.1 Design

This study employed a descriptive qualitative design, which included a simple demographic survey and semi-structured interviews.

2.2 Settings

This study was conducted in acute care settings that offered both general and specialized medical services, and where financial incentives for dementia care were applied.

2.3 Participants

Participants were recruited using a purposive sampling strategy to ensure the collection of rich and relevant data concerning the phenomenon under investigation. This strategy was chosen because clarifying the structure of difficulties in acute dementia care required participants who had navigated the transition from student to professional while directly managing the complexities of this specific environment. Inclusion criteria were: (1) registered nurses in their first year of clinical practice after licensure to capture experiences during the transition period; (2) experience caring for at least three older patients with dementia to ensure sufficient clinical exposure for reflection; and (3) approximately 12 months of experience in an acute care setting to allow for a retrospective account of the entire first year. Exclusion criteria included nurses working in intensive care units, rehabilitation wards, or recovery wards, to ensure a homogeneous sample from medical–surgical wards, where the tension between acute somatic treatment and the care needs of patients with dementia is most prevalent. Due to recruitment challenges, nurses with 16–17 months of experience were also included; however, all participants were asked to reflect specifically on their experiences during their first year of practice.

Both Japanese and international sources suggest data saturation occurs within a relatively small number of interviews

in homogeneous groups.[36,37] Data saturation was reached after 10 participants; one more was added for confirmation.

2.4 Data collection

Data were collected between July and August 2022. The demographic survey covered sex, age, education, department, prior contact with older people with dementia, the number cared for in the first year, and dementia-related training. The interview guide (see Table 1) was developed through team discussions among the authors, drawing on prior studies,[18,38,39] and was not pilot-tested. Data were primarily collected through semi-structured interviews, supplemented with field notes based on observations during the sessions. To maintain methodological transparency and deepen the understanding of participants' experiences, these field notes were used to document not only verbal responses but also non-verbal cues (e.g., facial expressions and gestures) and contextual observations during the sessions. All interviews were conducted either in person in private rooms or via a secure web-based platform. Interviews lasted 30–70 minutes and were recorded with participant consent; repeat interviews were not conducted.

2.5 Analytical methods

The KJ method (affinity diagramming)[40] is a creative problem-solving tool that captures complex phenomena, explores solutions, and structures them. Adapted for qualitative synthesis by Yamaura,[36] whose version is used in this study, it has since been widely used in fields such as psychology, education, and healthcare, and has also been applied in nursing research.[18] Visualizing complex relationships helps to clarify the challenges novice nurses encounter in dementia care.

Table 1. Interview guide

1.	Did you have any experience working with older people with dementia before admission? What was your relationship like? What perception did you have of older people with dementia?
2.	Immediately after admission, what did you think about caring for older patients with dementia?
3.	Have you experienced any difficulties in caring for older patients with dementia? If so, what were they? Please describe a specific case you experienced. How did you respond to the situation?
4.	Over the past year, has your image or sense of difficulty with older patients with dementia changed? If so, what kind of change? Please tell us why you felt this way.
5.	Did you consult your preceptor or other senior staff members when you had difficulties? What kind of feedback did you receive?
6.	What kind of training or workshops would you have liked to have had regarding dementia care? Please tell us why you feel that way.

According to Yamaura,[36] the process is as follows: (i) Code making: A verbatim transcript was generated and repeatedly read to identify the labels, each representing a single idea or thought. (ii) Grouping: Labels with similar associations were grouped, and the grouping continued until no further similarities appeared. The rationale for each group was summarized in a sentence and used as a new label for the subsequent grouping. The above procedure is repeated until five to seven final labels are generated—a size recommended in the KJ method.[36] (iii) Affinity diagram making: The relationships between the final labels were shuffled and carefully analyzed. These relationships were then represented using logical connectors, with their meanings noted. Finally, to represent the essence of each final label, a symbolic phrase—termed a "symbol" in this method—was generated.

In the KJ method, individual analyses are first performed to extract the logic of each case and understand its unique characteristics. Then, an overall analysis is performed, which involves theorizing based on the insights gained from the individual analyses.

2.6 Credibility and authenticity

The researchers who performed the analysis participated in a training session on the KJ method. Rigor was ensured through multiple strategies: two researchers independently reviewed the coding and grouping process, and discrepancies were resolved through discussion until consensus was reached. A qualitative research expert and KJ method instructor audited the final structure to enhance credibility and confirmability. An audit trail of analytical decisions was maintained to support dependability. Participant demographics and contextual details were provided to aid transferability.

2.7 Ethical considerations

This study was approved by The Ethics Review Committee, Graduate School of Nursing, Chiba University (No. NR3-100; Date of Approval: April 5, 2022). Five facilities meet-

ing the study criteria consented to participate, with approval granted by their nursing directors or deputies. Following the written provision of study information to head nurses, eligible participants were approached. The researcher explained the study's purpose, procedures, voluntary nature, and confidentiality. All participants provided both verbal and written informed consent.

3. RESULTS

3.1 Settings and participants

Five tertiary acute care hospitals (350-800 beds, all with financial incentives for dementia care) in the Kanto region—an eastern area of Japan that includes Tokyo and other major cities—participated. Table 2 shows participant demographics (N = 11; all female; 10 in early 20s, 1 in early 30s). Nine had prior in-depth contact with older people with dementia through personal or placement experiences, eight had attended a dementia care workshop (typically once for 1-2 hours), and one had previously worked part-time in a care facility during her student years.

3.2 Overall analysis

The overall analysis employed a total of 71 labels finalized from the individual analyses. These labels underwent a four-step grouping process, resulting in seven final labels and, subsequently, an affinity diagram illustrating their relationships and respective symbols (see Figure 1). Underpinned by ethical dilemmas involving the tension between ensuring patient safety and respecting patient dignity, novice nurses engaged in practice while navigating multiple difficulties. These included apprehension stemming from inexperience despite an awareness of their responsibilities, frustration arising from ineffective engagement despite repeated efforts, and emotional turbulence triggered by resistance from older patients with dementia. These difficulties—stemming respectively from being neophytes, the complexity of dementia, and the acute care environment—were interrelated, creating a complex and multilayered situation. As novice nurses continued their practice under such conditions and confronted the limits of their coping capacity, two emotions emerged as a common thread throughout their experiences: guilt over burdening others and inadequacy due to difficulty adapting and reliance on senior nurses' support. Ultimately, what emerged were the consequences of coping: ongoing challenges beneath a superficial sense of accomplishment, and a perceived need for earlier, more practical dementia care education.

Each symbol is presented in bold and described in detail using its corresponding final label in angle brackets (< >), representative raw data excerpts in quotation marks (“”), and participant identifiers in parentheses.

Table 2. Participants' demographic data

Participants	Education	Setting	Department	Nursing experience	1*	2**	3***	Labels
A	College	a	Internal medicine	16 months	No	Always	Yes	46
B	College	c	Surgical	16 months	Yes	Always	Yes	57
C	University	d	Internal medicine	16 months	Yes	Always	No	42
D	College	a	Mixed	16 months	Yes	Everyday	Yes	49
E	University	b	General practice	16 months	Yes	Always	Yes	47
F	College	c	Internal medicine	16 months	Yes	Everyday	No	43
G	University	d	Mixed	16 months	Yes	Always	Yes	41
H	University	b	General practice	16 months	Yes	Always	Yes	56
I	University	d	Mixed	16 months	Yes	Everyday	Yes	39
J	College	d	Internal medicine	16 months	Yes	Everyday	Yes	34
K	University	e	Internal medicine	17 months	No	Sometimes	No	31

*Previous in-depth contact with older people with dementia before employment. **Number of older patients with dementia under your care. ***Participation in workshops on dementia to date.

3.2.1 *Stemming from the discrepancy between nursing education and clinical practice: Ethical dilemmas between ensuring patient safety and respecting dignity*

<Although novice nurses had been taught the importance of ethical considerations during their nursing education, they were compelled to use physical restraints on older patients with dementia who exhibited dangerous behaviors within a safety-oriented organizational culture; imagining the situation from the perspectives of the patients and their families evoked feelings of pity and moral conflict, raised concerns about violating patient dignity, and ultimately led to ethical dilemmas.> The symbol expresses that it is difficult for

novice nurses to reconcile safety with respect for patient dignity.

One novice nurse, describing inner conflict over how families might view restraints, shared: “I often wondered what the patient’s family would think if they saw the restraints. I would feel bad if I or my family were restrained in the future. I had opportunities to discuss the significance of restraints with my preceptor, but they said, “We have to prioritize life and safety.” (A)

Another, reflecting on the challenge of balancing safety and dignity in practice, said: “I once cared for a patient with a fracture who had dementia, could not follow the bed rest instructions, and tried to stand up on their own, resulting in a fall. I understood that their inability to follow instructions was due to dementia, but we had to use restraints. I felt ethically distressed.” (B)

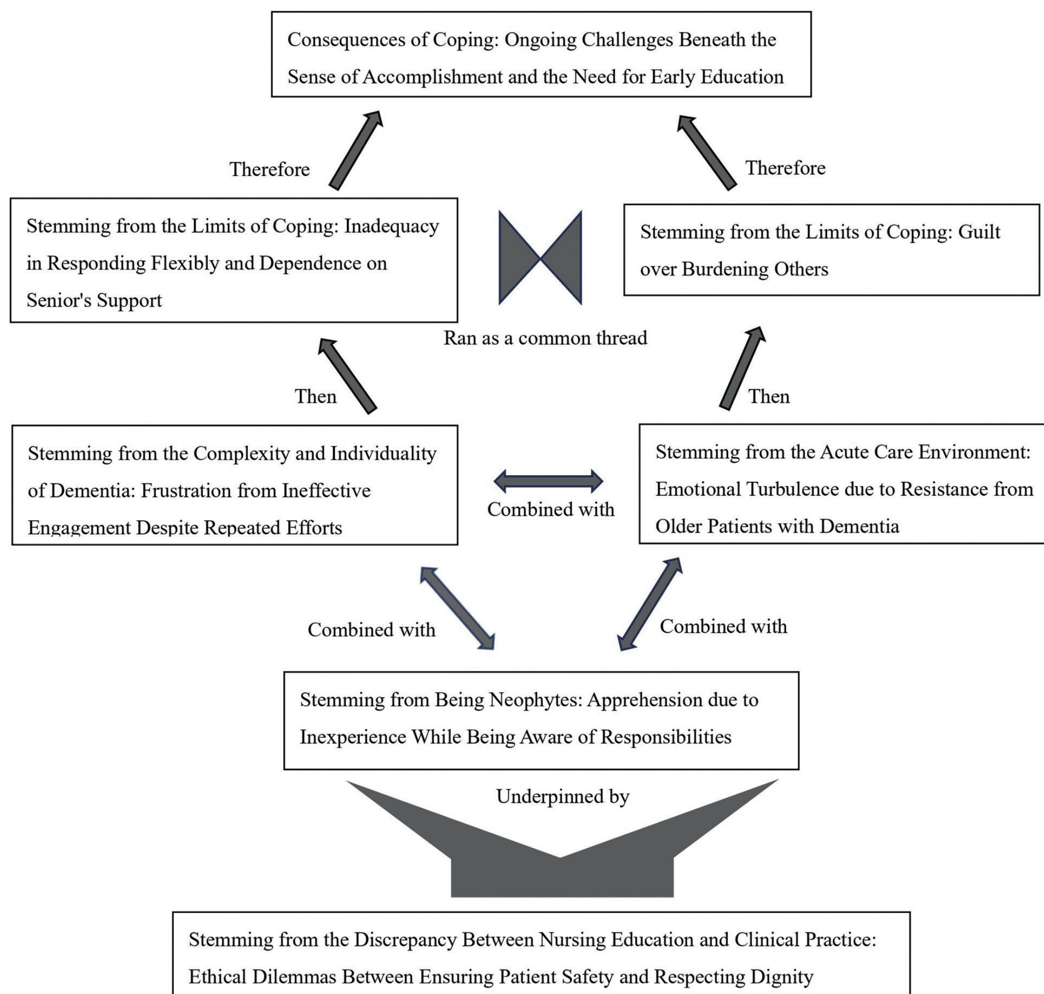

Figure 1. Structure of difficulties novice nurses encounter in caring for older patients with dementia in acute care settings throughout the year

A third novice nurse, describing the discrepancy between ideal and reality, shared: “According to textbooks, restraint is done for the sake of the patient, but in practice, sometimes it is done for executing duties.” (C)

3.2.2 *Stemming from being neophytes: Apprehension due to inexperience while being aware of responsibilities*

<After entering clinical practice, novice nurses accepted the reality of providing care to older patients with dementia—who often require advanced treatment and present unavoidable risks such as wandering and falls—but were nonetheless shocked by the difficulty of responding to such situations and felt uncertain about how to cope as beginners in the field>

This symbol encapsulates the shock, unpreparedness, and anxiety that novice nurses experience in acute dementia care.

One novice nurse, who had previously only interacted with

two people with dementia before employment, described: "Right after I started working, I realized just how many different types of patients there are, and that caring for them is even more challenging than I had imagined." (G)

Another nurse shared: "When I was working part-time, the older people with dementia I met were almost ready for discharge and not in very bad condition. But now, patients are being treated for severe physical conditions as well as dementia. It's already a matter of life and death for them. I am more nervous in the ward than before." (I)

One participant also expressed concerns about care quality when handling multiple patients alone: "During placement, I handled one patient with support; but at work, I sometimes had to care for three on my own. I worried I might negatively affect their care." (J)

3.2.3 *Stemming from the acute care environment: Emotional turbulence due to resistance from older patients with dementia*

<In the acute care setting, novice nurses, believing that negative emotions such as fear, frustration, sadness, and discouragement were inappropriate for nursing professionals, suppressed these feelings when essential nursing interventions—intended to ensure treatment and rest—were met with refusal or aggressive behavior by older patients with dementia, and began to question whether their own responses had been wrong> This symbol demonstrates that, in acute care settings, novice nurses recognized that medical tasks should be performed even when irritation arises, leading to an emotional and professional conflict.

One novice nurse, describing painful experiences of rejection, shared: "Even though I explained various things for their well-being, I was met with resistance through physical actions or words. At such times, I wondered why they reacted that way toward me, and it was painful." (A)

Another reflected on an episode of being struck by a patient while managing routine tasks: "I was just busy doing my tasks when he hit me. A part of me wanted to hit back, but I thought maybe he was trying to tell me something in the only way he could, and that it was my failure to understand him. I tried to suppress those tangled feelings and hold myself back." (J)

3.2.4 *Stemming from the complexity and individuality of dementia: Frustration from ineffective engagement despite repeated efforts*

<Despite repeated engagement, novice nurses struggled to interpret the individualized characteristics of restless behaviors and the underlying emotions, especially when compounded by communication difficulties, which contributed to a persistent sense of frustration> Participants felt frustrated at misinterpreting symptoms.

One novice nurse, describing the challenges of differentiating BPSD from delirium during night shifts with limited staff support, shared: "When I work the night shift, some patients exhibit delirium-like symptoms. It is difficult to distinguish." (G)

Another novice nurse, reflecting on the difficulty of guiding patients to express their needs, said: "Some patients didn't express their needs, so I had to ask in detail. Maybe he didn't remember me or didn't want to open his heart. I felt at a loss." (H)

Another participant, describing the time it takes to understand the individuality of each patient, shared: "I try to understand the patterns of people with dementia, but it really takes time. I have to read their behavior to understand them, and that part is difficult. When a new patient comes in, I often feel it's quite challenging." (J)

3.2.5 *Stemming from the limits of coping: Guilt over burdening others*

<Lacking sufficient knowledge and skills in dementia care and overwhelmed by multiple routine tasks, novice nurses found themselves mentally unprepared to properly face older patients with dementia, which led to delays and disorientation that burdened these patients, other patients, and senior nurses, ultimately resulting in feelings of self-blame> For novice nurses, dementia care adds a significant workload, requiring time, skills, and emotional energy as it impacts both patients with dementia and those around them.

One novice nurse expressed their distress over not being able to attend sufficiently to patients: "I felt truly sorry that I couldn't spend enough time with patients with dementia. There were times when, because I prioritized my tasks, a patient who probably wanted to go to the toilet ended up soiling themselves, and that really weighed on me." (B)

Another reflected on the burden placed on senior staff: "I felt guilty for troubling my senior nurses when I couldn't manage everything myself." (E)

Yet another novice nurse stated: "I felt I had to stay with dementia patients constantly, which sometimes delayed me in bringing medications to other patients. It was difficult, and I felt truly sorry." (G)

3.2.6 *Stemming from the limits of coping: Inadequacy due to difficulty adapting and reliance on senior nurses' support*

<Despite attempting to apply their basic knowledge and experience, novice nurses found responding to older patients

with dementia difficult and confusing, which led them to rely on senior nurses in challenging situations, and as they became more independent, they increasingly struggled with the limits of their abilities> Participants felt inadequate due to reliance on senior nurses and limited practical knowledge.

One novice nurse described the difficulty of bridging the gap between classroom learning and real-world practice: “The situation I’m in now is different. I was taught the important basics at school, but I’m expected to build on that, and that’s been challenging.” (E)

Another, reflecting on increasing responsibility and anxiety as senior support decreased, said: “By October or November, the severity of the patients I was responsible for had gradually increased. My seniors began to step back, and I had to take responsibility for my work. I felt a lot of anxiety at that time.” (F)

A further participant reflected on comparing themselves with experienced colleagues: “I admired the competence of senior nurses, while also being reminded of my own limitations.” (H)

3.2.7 *Consequences of coping: Ongoing challenges beneath the sense of accomplishment and the need for early education*

<While novice nurses developed a more constructive attitude toward caring for older patients with dementia and gained a certain degree of composure through a year of involvement, difficulties in dementia care persisted, highlighting the need for early-stage training> Participants reflected on their first-year experiences, expressing both improvements and ongoing challenges.

One participant expressed a continued sense of uncertainty despite increased exposure: “That vague sense of uncertainty hasn’t changed. Patterns and personalities differ so much that it’s hard to feel like things have gotten easier.” (I)

Another described a modest growth in confidence, while acknowledging that it stemmed from personal struggle: “Compared to when I didn’t know anything at all, I feel like I’ve grown a little and gained a bit more confidence in how I interact with people with dementia. It’s because I’ve had those experiences and struggled through them.” (K)

4. Discussion

This study highlights that novice nurses’ first-year dementia care in acute settings is shaped by safety–dignity dilemmas. They faced three interconnected difficulties—apprehension from inexperience, frustration from ineffective engagement, and emotional turmoil from patient resistance. These challenges fostered feelings of guilt and inadequacy and underscored the need for earlier dementia education.

Our findings also suggest a fundamental incompatibility between the fast-paced demands of acute care and the ideals of person-centered care (PCC) for older patients with dementia, which novice nurses had learned during their primary nursing education. Previous studies indicate that experienced nurses also encounter ethical conflicts when using restraints that diverge from PCC principles.[39,41] However, novice nurses, who are especially prone to reality shock, appear even more inclined to experience such dilemmas. Moreover, novice nurses tend to absorb the dominant values of their organizational culture and peers, even when these differ from their initial beliefs.[42] In this study, participants internalized safety-oriented norms from senior staff, which intensified ethical conflicts.

Although most participants had prior contact with older people with dementia, they felt unprepared and anxious about providing care in acute settings. This contrasts with the findings of a previous study, which reported that early exposure enhanced novice nurses’ confidence.[35] The discrepancy may be attributed to the limited depth or context of prior experience or training. In this study, 10 out of 11 participants had entered the workforce immediately after graduation, and only one had professional caregiving experience. Younger students (under 25 years) are more susceptible to the negative influence of prior experiences than older students.[43] Given that most participants were in their early twenties, their initial negative perceptions may reflect this tendency.

Patient falls have been identified as the most common incident involving novice nurses.[44] Similarly, participants in this study expressed serious concerns about the safety of older patients with dementia, especially due to their unpredictable behaviors and the need to manage multiple patients simultaneously. This mirrors concerns previously expressed by mid-career nurses,[13,18,45] but for novice nurses, such concerns are often intensified by anxiety about assuming clinical responsibilities. Despite this, participants demonstrated a strong sense of professional duty. Early orientation programs and adequate support are thus essential to enhance novice nurses’ understanding of dementia care and alleviate their apprehension.

This study also revealed the emotional distress novice nurses experience when encountering resistance from patients with dementia. Such resistance is common during acute admissions,[46] yet acute care environments often prioritize safety, symptom management, and efficiency over relational care. This may intensify patient resistance and exacerbate emo-

tional strain among staff.[12,18,46] Novice nurses, in particular, undergo a dynamic transition characterized by fluctuating emotions[29] and may experience disillusionment when clinical realities diverge from academic ideals.[47] These factors render them particularly vulnerable to emotional turbulence. To mitigate this, staff should share information on patients' histories and behavioral cues to support early recognition and proactive responses.

Participants also reported frustration with repeated failures to manage symptoms effectively. This aligns with earlier research identifying gaps in novice nurses' clinical, communication, and decision-making skills.[48] The high prevalence of BPSD,[5] communication barriers,[7] and patient variability[8] further complicate dementia care. These results underscore the need to integrate management with person-centered approaches.

Novice nurses in dementia care frequently experience guilt about burdening others, which is closely intertwined with a persistent sense of inadequacy. These feelings can be attributed to three interrelated factors. First, the hospitalization of patients with dementia places heavy demands on nurses, who must manage multiple patients simultaneously while coping with unpredictable behaviors, leading to stress and delayed care for others.[10,39] Second, insufficient time and skills limit their ability to provide high-quality, person-centered care, while routines and fatigue leave little learning opportunity. Many consequently adopt a task-oriented approach, which hampers their capacity to address complex care needs.[17,49] Third, frequent reliance on senior staff reinforces feelings of dependence and guilt about imposing on others. Together, these factors amplify novice nurses' feelings of guilt and inadequacy and highlight the need for protected time and structured, context-sensitive support to facilitate learning and engagement in dementia-specific training.

Younger nurses remain vulnerable to being overwhelmed by the complexity of dementia care, even after training.[17] Similarly, in this study, all eight participants who had received dementia-related training continued to face significant challenges. This highlights the need for continuous, experience-sensitive education tailored to the developmental stages of novice nurses. Despite these difficulties, participants gradually improved in attitudes and responsiveness during their first year. They emphasized the need for structured dementia care training tailored to their evolving needs, highlighting the importance of flexible programs that combine foundational knowledge with opportunities for practice and reflection.

The structural framework identified in this study highlights that the difficulties experienced by novice nurses in acute dementia care are not isolated issues but are dynamically interconnected. Ethical dilemmas between patient safety and dignity underpin multiple challenges, while inexperience, the acute care environment, and the complexity of dementia interact to intensify emotional burden, guilt, and feelings of inadequacy. Importantly, the framework indicates that support needs differ across stages of the transition period and must address not only skill acquisition but also emotional and ethical challenges.

At the educational perspective, the framework suggests that support should be tailored to novice nurses' stage of transition. In the early phase of employment, accessible resources such as e-learning should be offered to mitigate initial shock and emotional fluctuations. These programs can provide essential dementia care knowledge, including communication strategies, recognition of BPSD, and self-protection in situations of verbal or physical aggression. E-learning has been shown to improve nurses' knowledge and confidence,[50] while staff training in aggression management reduces workplace violence and its negative effects.[51] Creating a safe work environment is therefore essential to support novice nurses' transition and well-being. In addition to early support, ongoing educational interventions, such as structured reflection, are essential to mitigate transition shock and promote adaptive coping.

At the practical perspective, as novices gain experience and begin independent practice, timely preceptor follow-up becomes increasingly important. Preceptors familiar with available resources can support novices in interpreting complex situations and applying knowledge in practice, fostering the transition from novice to expert.[52] In addition, the framework underscores the importance of shifting support from an individual focus to team-based approaches. Strengthening team-based support through regular case conferences, interdisciplinary collaboration, and participation in dementia care team activities allows ethical tensions to be shared and responsibility for risk management to be distributed. Such approaches may help novice nurses contextualize challenges within the care environment rather than internalizing them as personal failures. Organizational and team-based support has been shown to facilitate ethical decision-making in complex clinical situations.[53]

At the policy perspective, the findings highlight the need for organizational structures that alleviate the cumulative burden on novice nurses caring for older patients with dementia in acute care settings. Policies should ensure access to specialized dementia care teams, protected time for learning, and continuity of preceptorship throughout the first year. Further-

more, restraint-reduction initiatives must be accompanied by practical and organizational support to enable novice nurses to navigate safety–dignity tensions without excessive moral distress.

Limitations and future research

This study has several limitations. First, all participants were female, which reflects the overall gender distribution of nurses in Japan, where male nurses account for only 8.6% of the workforce.[54] Second, participants were recruited exclusively from acute care hospitals that receive financial incentives for dementia care. As a result, the findings may not be generalizable to hospitals without such incentive programs or to different cultural contexts. Nevertheless, the persistence of difficulties despite these incentives underscores the need for tailored dementia care education in all acute care settings. Third, as with all retrospective qualitative studies, recall bias is possible, although this risk was minimized by conducting interviews soon after participants' first year of practice. Future research should empirically test targeted educational and organizational interventions, building on the interaction structure identified in this study to develop stage-sensitive support strategies for novice nurses.

5. Conclusion

This study visualized the complex difficulties novice nurses face in providing dementia care in acute settings, revealing their interrelated nature and ethical underpinnings. By clarifying this interaction structure, the study offers a foundation for developing multidimensional, stage-specific support strategies. Approaches such as e-learning, timely preceptor follow-up, team-based case discussions, and participation in dementia care team activities can help strengthen novices' competencies, reduce emotional distress, and enhance the quality of dementia care. These findings highlight the need to integrate person-centered care principles into acute hospital practice and may inform nursing education and organizational policies aimed at supporting novice nurses and improving dementia care in aging societies worldwide.

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Authors contributions

Tingting Chen: Conceptualization, Methodology, Investigation, Data curation, Formal analysis, Validation, Visualization, Writing – original draft. Toshihiro Ono: Methodology, Formal analysis, Validation, Writing – review & editing. Harue Masaki: Conceptualization, Methodology, Formal analysis, Supervision, Writing – review & editing. All authors approved the final version of the manuscript and agreed with its content. No authors contributed equally to this work.

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Informed consent

Obtained.

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Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Data sharing statement

No additional data are available.

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