

Missed Nursing Care

A Qualitative Study

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The purpose of this study was to determine nursing care regularly missed on medical-surgical units and reasons for missed care. Nine elements of regularly missed nursing care (ambulation, turning, delayed or missed feedings, patient teaching, discharge planning, emotional support, hygiene, intake and output documentation, and surveillance) and 7 themes relative to the reasons for missing this care were reported by nursing staff. **Key words:** *basic care, missed nursing care, nursing care, outcomes, patient safety, quality, staffing*

ENSURING quality nursing care and patient safety is a major challenge facing nurses and nurse leaders today. Research studies have shown links between the level of nurse staffing and mortality/failure to rescue,¹⁻⁴ infection rates,⁵ pressure ulcers,⁶ patient falls,⁷ length of stay,^{5,6} adverse events,^{8,9} complications after surgery,¹⁰ and patient satisfaction.¹¹

The specific aspects of missed nursing care potentially leading to the association between less staffing and the negative outcomes have not been established in research. Clarke and Aiken pointed out that nurses serve the surveillance function in hospitals to prevent errors and ensure quality care, and too few staff lead to insufficient surveillance.¹² It is not clear though what other nursing care omissions lead to poor patient outcomes. A literature search revealed a lack of studies on specific aspects of nursing care missed rou-

tinely and nursing staff reasons why these elements of care are prioritized as less important than others.

RESEARCH QUESTIONS

The research questions for this study were as follows: (1) What nursing care is regularly missed on medical-surgical units in acute care hospitals? and (2) What are the reasons nursing staff give for not completing these particular aspects of care?

STUDY METHOD

This qualitative study used focus group interviews with nursing staff on medical-surgical units in 2 hospitals—a 210-bed hospital in the southern region and a 458-bed regional medical center in the northern region of the United States.

Sample

A total of 107 registered nurses (RNs), 15 licensed practical nurses (LPNs), and 51 nursing assistants (NAs) working in medical-surgical patient care units were interviewed in 25 focus groups. The staff members were segregated by job title in the focus groups to maximize the communication of issues that they may be reluctant to verbalize with other members of the team present.

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Data collection

The focus group interviews used a semistructured design. Each focus group lasted 90 to 120 minutes. Focus group participants were asked to commit to confidentiality (not to quote the others in the group outside the focus group). They were assured of confidentiality of their comments by the investigator and encouraged to be as open and honest as possible.

Data analysis

All interviews were tape-recorded, fully transcribed, and analyzed initially by a research associate. The author then analyzed the interview transcripts independently using NVivo by QRS International,¹³ a qualitative analysis software, and applying a grounded theory approach by which empirical data are thematically categorized by induction.¹⁴ The second analysis revealed that the themes from the first and second analyses, although differently grouped, extracted the same issues from the empirical material. This was taken as a confirmation of the grounding of the analysis in the data. To be included as a theme, supporting data had to be contained in focus groups from both hospitals and in all of the focus groups. Extracts from interviews are indexed RN, LPN, and NA

STUDY FINDINGS

Missed nursing care

The focus group members were asked whether there were aspects of care missed on a regular basis. They were informed that the focus of this study was on repeated omissions of care, not on the occasional occurrence or care that is missed in an emergency or in a noncrisis situation. All of the focus group members stated that they did not, or were not able to, provide all of the nursing care that patients needed. For example, an RN commented: "We have to give them meds to keep them alive, we have to make sure they can breathe, and we have to keep the heart going. Things after that get missed."

All of the RNs and LPNs and many of the NAs expressed a high level of regret, guilt, and frustration that they were not able to complete all of the care for their patients. For example, an RN stated, "People want to give good care and it bothers all of us when we can't do it. You are pulled in 10 directions, and you can't give quality care to your patients. It really bothers me."

The following 9 themes of regularly missed nursing care nursing staff were extracted from the focus groups: ambulation, turning, feedings, patient teaching, discharge planning, emotional support, hygiene, intake and output documentation, and surveillance.

Ambulation

One area of missed care was ambulation of the patients. A few staff members stated that they "try" to ambulate the patients but often failed to do so. For example:

NA: Sometimes a nurse will come and ask, 'Can you walk this patient if you get time?' If we get time, we can do it. But if we don't, we can't do it. We don't do it.

Occasionally 1 or 2 nurses in the focus groups stated that they believed the NAs were ambulating the patients; however, the NAs on the same unit reported that they rarely, if ever, ambulate the patients. Other participants from the same unit in one of the hospitals reported that they ambulated their patients "because the physicians always ask if we have got the patients up when they make their rounds."

Turning

The staff said that it was more likely that patients were turned than ambulated. However, the focus group participants indicated that instead of every 2 hour turns, they often turned the patient every 4, 6, or 8 hours or even longer.

Delayed or missing feedings

Another element of nursing care lacking was feeding patients in a timely manner. Occasionally patients were not fed at all. One of 2 scenarios was described: (1) the food on the

tray gets cold and has to be microwaved, making it less tasty, or (2) dietary picks up the tray before the patient is fed. An RN commented: "You would really be surprised to find out how many trays get returned to dietary untouched because no one got around to feeding the patients." For patients able to feed themselves, the focus group participants noted that many times they had difficulty setting the patient up so they could feed themselves before the food got cold.

Patient education

Another area of missed nursing care identified by all of the RNs and LPNs, and many of the NAs, was patient teaching. Selected comments by RNs included the following: "I never have time for diabetic teaching." "If you want to get out on time, do you think you do as much teaching as you really should, or do you turn around and run for the computer to get your charting done?" and "An example of what happens when we don't provide adequate education is the patient winds up with a stroke because they didn't take their medication. But we don't get to it most of the time."

Discharge planning

Discharge planning was another area that nurses reported was not regularly completed. Many nurses think that the case managers take care of this aspect of nursing care, but admitted that they were often unaware of the details of the patient's preparation for discharge. For example, an RN stated, "I really rarely know much about where the patient is going after hospitalization and whether there have been adequate preparations made."

Emotional support

Another area of missed care identified by all of the participants was emotional support. The staff emphasized that providing support to the patient and family was important to them, an element of care they deeply valued, and was frustrating not to meet these patient and family needs. For example, "You are busy so you do not have time to spend with the patients. I know the patient needs to talk with

me, but I am afraid of getting in a situation where I can't easily get away." Another RN stated,

There's many times when I've been in the room listening to somebody and my beeper goes off with two or three rings. I feel like, Great, now I have to tell this person, I'm sorry, can you hold that statement so I can go check on these two or three other people? That to me is saying that this person isn't important and that's what they're feeling. I'm not important because she has to go to another room.

It also was evident that the nursing staff did not consistently conduct an assessment of the patient's psychosocial needs. "I really don't have time to do a thorough assessment [of the patient's psychosocial needs]. You can just see when you go in the room that the patient is distressed, but there really isn't time to get involved."

Hygiene

Another area of care missed on a regular basis was hygiene, specifically baths, keeping patients clean, and completing mouth care. An RN stated, "We have patients that haven't had a bath in 2 to 3 days." Another commented, "They don't always get a bath or their bed changed. One day I came to work, I had 3 patients' 'on strike.' One refused to get back into her bed until the sheets were changed. Another one needed a bath, and it is just crazy."

Intake and output documentation

Accurately measuring and documenting intake and output also were reported as an area of missed nursing care. Some of the obstacles to this described by nursing staff included the following: the tray being picked up before the staff recorded what was eaten, patients going to the bathroom when the staff were not present, and a lack of a systematic way to record the filling of water pitchers, among others.

Surveillance

Surveillance was identified as inadequate particularly when nurses were assigned to patients in physically distant locations on the

unit. An RN stated, "I hold my breath as a leave one wing and round the corner to the other wing. I think it has been an hour since I was in his room. Will he be alright?" The staff were anxious when they were caring for a patient and the others were not being observed adequately. For example, "Sometimes you have to remind yourself to go in a room to a patient who is pretty much taking care of themselves. You say 'Oh my God! I've been so busy with these other ones, I haven't been in his room.'"

Reasons for missed care

Seven themes relative to the reasons that particular aspects of nursing care were routinely missed emerged from the focus groups: too few staff, time required for the nursing intervention, poor use of existing staff resources, "It's not my job" syndrome, ineffective delegation, habit, and denial.

Too few staff

When the focus group participants were asked why selected aspects of nursing care were missed on a regular basis, it was not a surprise that the first response was too few staff members. Three overall situations creating short staffing identified were (1) an inadequate staff-to-patient ratio in the first place, (2) shifts in which the full complement of budgeted staff was not present (eg, absence due to sickness and unfilled positions), and (3) unexpected heavy work demands (eg, declining health of a patient and a large number of discharges and admissions).

Time required for a nursing intervention

The length of time it takes to complete a nursing intervention influenced the priority it was assigned by the nursing staff. Both nurses and NAs stated that nursing care that involved a considerable amount of time was more likely not to be completed. Particularly time-consuming nursing interventions identified in the focus groups included ambulation, patient teaching, discharge planning, psychological support, and hygiene. Comments by RNs included "Ambulation takes such a long

time. I think that is why it doesn't get done a lot of time" and "Teaching takes so much time, we just give up and don't try."

Participants indicated that it was hard to extract themselves from patients once engaged in providing emotional support. For example, "The ability to say something more than 'I'm your nurse, I have your pills, and how do you feel?' is very important. The patients need more than that, but you are not able to do more. If you do, it will put you behind. Something as simple as fixing their pillow and blankets can become too time consuming because you are so busy." Baths were identified as time consuming by the NAs.

Poor use of existing staff resources

Another theme was the poor use of existing staff resources. Seven major subthemes in this category emerged as common in both hospitals where the study was conducted. The first subtheme was too few of a particular category of staff, usually NAs. For example, an RN stated, "It seems when it is better for the nurse, it is worse on the attendant. We go from nursing home type care where we don't need as many RNs, but a lot more aides, and then it will be that you have a lot more critically sick patients so you don't need as many attendants."

Other subthemes included too many inexperienced staff on a given shift; making patient assignments based solely on numbers, not workload requirements; inconsistent patient assignments from day to day; not having the supplies and equipment, including medications; inadequate orientation of new staff; and handoff problems shift-to-shift and from the emergency department and operating room to the patient care units.

It's not my job syndrome

The "it's not my job syndrome" theme was prevalent in the focus group discussions. Many nurses considered the work delegated to the NAs as no longer the RNs' responsibility. One way this syndrome was expressed was by nurses looking for the NA to do something for the patient that they could have completed

more efficiently themselves. For example, an NA explained: "Sometimes a patient can ask a nurse to give them a bed pan or a cup of water, and they come find you to do it when they are right there in the room. The excuse is I have to give them medicine, but you have to wash your hands anyway. Why not just do that instead of coming looking for me?"

On the other hand, the NAs sometimes reported feeling that certain tasks were the responsibility of the nurses, not theirs, even if it was in the NA's job description. For example, an NA stated, "Why do they expect us to do their patients' vital signs, can you please tell me? That is their job. What is it for the nurse when they have five patients to take five vital signs on their own patients? They can do them."

Another instance of this syndrome reported in the focus groups centered on the role of the physical therapist (PT) in the ambulation of patients on the units. The nursing staff reported that they believed all ambulation was PT's job. Yet they also stated that the patients were not ambulated enough. Still another example was the "delegation" of responsibility for discharge planning entirely to the case managers.

Ineffective delegation

Another contributor to the problem of missed care was ineffective delegation. Three subthemes emerged. The first subtheme was failure of the nurse to obtain the buy-in of the NA. Many of the focus group participants stated that the NAs did not attend report with the nurses or receive report from them. Even when the NAs received report, there was a lack of collaborative planning for patient care.

The second subtheme was nurses delegating without retaining accountability. Nurses stated that certain tasks such as vital signs were the NA's responsibility, and if the NA did not complete these tasks, it was the "fault" of the NA, not the RN. The third subtheme was the lack of conflict management skills. Many nurses reported limited authority and influence over the NAs and expressed a reluctance to confront NAs who did not "do their job."

All of the staff indicated that it was difficult for them to engage in conflict and many tried to avoid it if possible. For example, an RN explained: "You ask them to do something, which is part of their job description, and they will give you an attitude, give you a hard time about it or just flat out say 'NO.' You end up doing their job, and it puts you behind."

Habit

Another theme was that nursing staff "get used" to *not* completing certain aspects of care. According to the participants, once an aspect of care, such as ambulation, is omitted, it becomes easier to omit it the next day and then the day after that. If the omission occurs for an extended period of time, the expectation that it will be completed disappears altogether. An RN stated: "To be honest, when you skip ambulation one day because you don't have time, and nothing happens, even though we know the patient goes home debilitated, I think it is easier to skip it the next day, and the next and the next."

Denial

Nurses reported engaging in denial about the care that was not completed, particularly care they delegated to others. Many nurses do not question whether certain care was completed by the NA or PT, but rather assume that it was done because underneath they "do not want to know that care is being missed." In fact, they reported that they avoid asking for fear that it has not been done: "We don't let ourselves think about it. It is the way we cope. Underneath we don't feel good about it."

DISCUSSION

The results of this study reveal that important elements of nursing care are being missed on a regular basis in acute care hospitals on medical-surgical units. These findings shed light on what is happening at the point of delivery, which may contribute to poor patient outcomes. A few studies that examined the frequency of nurse interventions such as ambulation corroborate these

findings. For example, Callen and Mahoney,¹⁵ in their study of the frequency of hallway walking by adults hospitalized on a medical unit, found that only 19% walked once, 5% twice, and 3% more than twice, and 73% did not walk at all. Similarly, Rasmussen and Kondrup¹⁶ found that nearly 40% of hospitalized patients were malnourished, and only a small proportion had a nutrition plan.

The areas of omitted nursing care uncovered in this study—ambulation, turning, delayed or missed feedings, patient teaching, discharge planning, emotional support, hygiene, intake and output documentation, and surveillance—may have a negative impact on patient outcomes, both quality and cost. For example, failure to ambulate and turn patients has been linked to new onset delirium,¹⁷ pneumonia,¹⁸ increased length of stay and delayed discharge,¹⁷⁻²⁰ increased pain and discomfort,²¹ and physical disability.²²

Similarly, undernutrition also has been associated with morbidity and mortality of hospitalized patients. McWhirter and Pennington found that 40% of the hospitalized patients were malnourished on admission and that 75% lost further weight during hospitalization,²³ while other studies demonstrated that malnourishment was associated with increased length of stay, more prescriptions, a higher rate of infection, greater mortality, delayed functional recovery, and higher rates of nursing home use.²⁴⁻²⁶

The failure to adequately teach patients and prepare them for discharge has also been shown to have negative outcomes. In a survey of patients discharged from medical-surgical units, almost half stated that they needed additional information or specific directions concerning their self-care.²⁷ Forster and colleagues found that adverse drug events were not only common, but many were preventable or ameliorable.^{28,29} In a study of the transition from hospital to home, discharged patients reported that a lack of adequate education was one factor that led to readmission to the hospital.³⁰

Inadequate staffing was a major reason that aspects of nursing care were not completed.

Many studies have pointed to the relationship between number of patients per nurse and negative outcomes.¹⁻¹¹ Rothberg's study showed that 8 patients per nurse was the least expensive staffing but was associated with the highest patient mortality while a nurse-to-patient ratio of 1:4 was the most expensive but resulted in the lowest mortality.⁴ Actual staffing ratios on the units studied were 1 nurse to 5-6 patients on days and evenings, and 1 nurse per 6-7 patients on nights. Rothberg also pointed out that lower ratios were most cost-effective when lower ratios shortened length of stay.⁴ As already noted, many of the specific elements of care missed by nurses have been shown to contribute to longer lengths of stay.

Another finding of this study, which supports the notion that increased staffing would prevent missed nursing care, is that staff decided to omit care that was time consuming (eg, patient teaching, psychologic support, and feeding). It is reasonable to assume that better staffing ratios would result in less missed care.

However, the findings of this study suggest that improving staffing ratios alone, while important, may not fully solve the problem of missed nursing care. Other factors contributing to the problem of missed nursing care revealed by the focus group participants included inadequacy of support services, lack of assumption of accountability by the nurses, poor delegation skills on the part of nurses, lack of adequate support for inexperienced nurses, patient assignment practices, and lack of supplies and equipment when needed.

It appears that the available nursing manpower resources are not being maximized or used to the fullest. Nursing staff are using time that could be devoted to patient care in obtaining supplies and equipment and repeatedly contacting other departments to coordinate care. They are also losing potential patient care time and increasing the incidences for missed care by the way they are making patient assignments, their failure to delegate effectively, and the lack of teamwork.

Another finding of this study is that nurses appear to cope with the problem of missed care by prioritizing aspects of care ordered by physicians or asked about regularly by the physician. The consequence of this behavior may be that routine basic nursing care is the least likely to be completed.

The fact that missed nursing care was more prevalent in areas where the impact was not immediately apparent is also noteworthy. The impact of not ambulating or educating patients, for example, may not be readily apparent until the time of discharge or after the patient goes home or to another care facility. Nutritional deficits are also not immediately discernable. Yet nurses were able to verbalize the consequences of not completing these aspects of care.

This study suggests that nurses use denial as a coping mechanism to deal with missing care. Tasks and responsibilities delegated to the NA, PT, and case manager are "assumed" by the nurse to have been completed. Yet upon further probing, nurses admitted that they were not at all sure that this care was being provided. While this is obviously an instance of poor delegation, it may also be a coping mechanism nurses use to deal with their feelings of guilt or low self-esteem relative to their performance as a nurse.

The impact on quality of care and patient safety of the use of denial by nurses is potentially far-reaching. For example, the findings of this study suggest that nurses may not be consistently conducting assessments of the patient's psychologic status. Nurses may be avoiding making these assessments, consciously or unconsciously, because they are concerned about getting "caught" for a potentially long period of time in one patient's room, causing them to fall behind in their work.

IMPLICATIONS FOR PRACTICE

The results of this study suggest a number of actions that nursing staff and managers can employ to decrease the problem of missed nursing care. First, nursing staff need to be engaged in the collection and analysis of data relative to missed nursing care on their units. Creating a culture of quality and safety that ensures attention to detail and honest reporting of omissions of nursing care would foster reporting of missed nursing care. Once the problem is fully recognized, root cause and other analyses need to be completed to determine the causes of the problem and strategies to address them.

It is clear that nurses are often distracted from care by situations such as insufficient supplies and equipment, new graduates, patient assignments based on numbers rather than on acuity of the patients, inadequate staffing, and a lack of teamwork. Resolution of these unit operational problems would increase the time the nursing staff have to provide actual care. Nurses also should be engaged in delegation training and performance follow-up so that they can appropriately manage those staff members working with them.

FUTURE RESEARCH

This study took place in only 2 facilities. Additional studies are needed to determine the validity of these findings. The development of a tool to measure missed care quantitatively would enable researchers to access varying levels of missed care and determine the conditions under which care is not completed. For example, what is the relationship between staffing patterns and missed nursing care? The answers to such questions would shed light on the relationship between nursing actions and patient outcomes.

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