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RESEARCH ARTICLE (ORIGINAL)

Missed nursing care: perception of nurses from a Portuguese oncology hospital

Cuidados de enfermagem omissos: perceção de enfermeiros de um hospital de oncologia português

Cuidados de enfermería omitidos: percepción de los enfermeros en un hospital de oncología portugués

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Abstract
Background: Delayed or unfinished care compromise patient safety. Prevention of missed nursing care (MNC) is one of today's challenges.
Objective: To identify MNC perceived by the nurses of an oncology hospital.
Methodology: Qualitative descriptive study based on some assumptions of case studies. The sample consisted of 10 nurses. Data were collected through semi-structured interviews after receiving the participants' informed consent.
Results: The main category was MNC, and the subcategories were definition, impact, and typology. The participants considered that the definition of this issue has consequences for the several care agents, impacting the patient/family, the nurse, and the profession. Regarding typology, the care related to the affective/relational dimension of caring, the technical component, the interdependent activities, and the healthcare delivery support activities were reported as missed care.
Conclusion: This study provided a contextual knowledge of this issue that justified the importance of understanding the reasons for the omission of these aspects of care to redesign nurses' practices.

Keywords: missed nursing care; nursing; patient safety; medical oncology

Resumo
Enquadramento: Os cuidados de enfermagem, deixados por fazer ou adiados, comprometem a segurança do doente. A prevenção de cuidados de enfermagem omissos (CEO) constitui um dos desafios da atualidade.
Objetivos: Identificar os CEO percecionados pelos enfermeiros de um hospital de oncologia.
Metodologia: Estudo descritivo de natureza qualitativa assente em pressupostos do estudo caso. A amostra foi constituída por 10 enfermeiros com aplicação de entrevista semiestruturada. Obtido consentimento informado dos participantes.
Resultados: Apurou-se como categoria central: CEO, constituída pelas subcategorias, definição, impacto e tipologia. Para os participantes, a definição da problemática acarreta implicações para os diferentes agentes de cuidado causando impacto no doente/família, no enfermeiro e na profissão. Quanto à tipologia, foram reportados como omissos os cuidados relacionados com a dimensão afetiva/relacional do cuidar, componente técnica, atividades interdependentes e de suporte à prestação de cuidados.
Conclusão: Obteve-se um conhecimento contextual desta problemática, tornando-se relevante a investigação sobre as razões subjacentes à omissão destes cuidados por forma a que se redesenhem as práticas dos enfermeiros.

Palavras-chave: cuidados de enfermagem omissos; enfermagem; segurança do doente; oncologia

Resumen
Marco contextual: Los cuidados de enfermería, dejados por hacer o pospuestos, comprometen la seguridad del paciente. La prevención de los cuidados de enfermería omitidos (CEO) constituye uno de los desafíos actuales.
Objetivos: Identificar los CEO percibidos por los enfermeros de un hospital de oncología.
Metodología: Estudio descriptivo de naturaleza cualitativa basado en los presupuestos de los estudios de caso. La muestra consistió en 10 enfermeros y se utilizó la entrevista semiestructurada. Se obtuvo el consentimiento informado de los participantes.
Resultados: Como categoría central se constató CEO, constituida por las subcategorías definición, impacto y tipología. Para los participantes, la definición de la problemática conlleva implicaciones para los diferentes agentes de cuidado, que repercuten en el paciente/la familia, en el enfermero y en la profesión. En cuanto a la tipología, se indicó como omitidos los cuidados relacionados con la dimensión afectiva/relacional del cuidado, el componente técnico y las actividades de cuidados interdependientes y de apoyo a la prestación de cuidados.
Conclusión: Se obtuvo un conocimiento contextual de esta problemática y la investigación de las razones subyacentes a la omisión de estos cuidados se hizo relevante para rediseñar las prácticas de los enfermeros.

Palabras clave: cuidados de enfermería omitidos; enfermería; seguridad del paciente; oncología médica

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Introduction

Patient safety and quality health care have been enhanced worldwide through the implementation of evidence-based guidelines with proven efficacy (World Health Organization, 2017).

Missed nursing care (MNC) occurs when required patient care are omitted or seriously delayed in nurses' daily practice, making it an important indicator of nursing care quality and patient safety (Kalisch, 2015).

The international literature highlights oncology services as protective environments for the incidence of MNC when compared to other hospital units, for which reason the analysis of this phenomenon in these settings has been neglected over the past few years (Jones et al., 2015).

Few studies have been published on the characterization of MNC in oncology units, and even fewer studies have addressed nurses' perception of this phenomenon (Villamin et al., 2018).

The contextualization of MNC is essential for implementing corrective measures to restructure nursing services, minimizing this problem and enhancing patient safety and quality care (Smith et al., 2017). Hence, this study aims to identify nurses' perception of MNC in an oncology hospital.

Background

The first study that intentionally addressed MNC was published in 2006. In this study, the authors defined MNC as a multifactorial outcome that consisted of omitting the whole or a part of some nursing activities (Dehghan-Nayeri et al., 2018).

Less prioritized care and MNC are associated with instrumental care, that is, the practical component of caring: patient lifting and ambulation, positioning, feeding, body and oral hygiene care, and hand hygiene (Jones et al., 2015).

The relational dimension of caring is also reported as an omitted aspect of care, with emotional support, communication with the family, and patient/family education being reported as frequently missed care (McMullen et al., 2017).

Thus, although basic care and care related to nurses' autonomous interventions are more often reported as MNC, interdependent interventions are also reported as omitted, particularly the monitoring of vital signs and capillary blood glucose and the administration of therapy within 30 minutes after its prescription (Jones et al., 2015).

The planning and update of the nursing process and nursing records were also reported as missed care in clinical practice (Lake et al., 2016).

The decision to omit a particular aspect of care may have consequences for patients, compromising safety, causing functional limitations, and increasing the risk of pressure ulcers, healthcare-associated infections, post-discharge complications and readmissions, length of hospital stay and costs, and mortality rates (Recio-Saucedo et al., 2018).

Research question

Which MNC are perceived by the nurses of an oncology hospital?

Methodology

This is a qualitative descriptive study based on some assumptions of case studies. It received the positive opinion of the research and ethics committee of the health unit under analysis.

The population was composed of nurses who worked in inpatient units of medical specialties of an oncology institution for more than 1 year.

The milieu sampling technique (Poupart et al., 2008) was applied, and the sample consisted of 10 nurses intentionally selected based on ease of access to the researcher.

A self-administered questionnaire for the participants' sociodemographic and professional characterization and a semi-structured interview guide were elaborated.

Data were collected from 5 September to 9 October 2018, after informed consent was sought and obtained from each participant. The interviews lasted on average 50 minutes and were held on a place, day, and time agreed upon by the researcher and the participants according to their preferences and the requirements for the interviews.

After each audio-recorded interview, data were transcribed and analyzed according to the stages of Bardin's content analysis technique (2016): pre-analysis, material exploration, and treatment of results (inference and interpretation). The data in the questionnaire were analyzed using descriptive statistics.

The following principles inherent to the nature of this study were ensured: the respect for self-determination – the participants gave their informed consent; the right to withdraw from the study without any harm or penalty; and the respect for the informants' confidentiality and anonymity – the interviews were coded based on the order in which they were held (from I1 to I10). The recordings, the full interview transcripts, the consents, and the completed questionnaires were deleted at the end of the study.

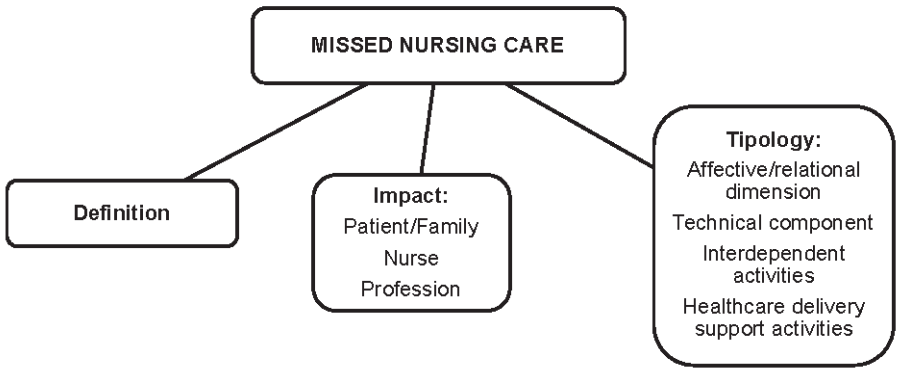
Results

Participants were mostly women (80%). Their mean age was 37.9 years, with a standard deviation (*SD*) of 6.33 years, a minimum of 27, and a maximum of 49. The mean length of professional experience was 14.9 years (*SD* = 6.03), with a minimum of 4 and a maximum of 23. Regarding their education level, 20% of the nurses had a master's degree, and 20% reported having the title of *specialist nurse* conferred by *Ordem dos Enfermeiros* (Portuguese nursing and midwifery regulator). On average, nurses had been working in the units for 11.9 years (*SD* = 5.5), with a minimum of 2 and a maximum of 17; 100% of nurses reported working in shifts, and 70% worked on average 5 hours more per week than contracted hours.

The content analysis process identified the main category - Missed nursing care - and three subcategories: Definition, Impact, and Typology, as shown in Figure 1.

Figure 1

Results of the content analysis of the semi-structured interviews



According to participants, the Definition of MNC concerns the whole or a part of nursing care that is not performed due to several factors: "they are omitted in practice, but they were planned to be performed to ensure quality in practice" (I5; I9). Participants mentioned the lack of assessment of their performance or the lack of record keeping as part of the omission, which may be intentional:

> these are aspects of nursing care that should have been performed because they were planned; however, consciously or unconsciously, they are left undone, either completely or partially (I9; I1; I10)

Participants believe that this situation has consequences for the several care agents. The Impact can be analyzed from the perspectives of the patient/family, the nurse, and the profession.

Concerning the patient and the family, the omission of planned care or the delivery of care without taking into account the identified needs and best practices contribute to the "potential worsening of the patient's health status" (I6) and consequent harm to the family.

Regarding the nurses, when nursing care are not delivered safely and do not meet the patients' individual needs, it weighs on the nurses' conscience because they are aware that required care are not delivered due to unavailable resources.

> MNC have risks. And it's not only clinical risks... it's also professional risks because nurses have ethical principles and a conscience... and if they care for their profession and have a good character, I don't think they're okay with their conscience when they should have done something and didn't do it... and for the patient this means MNC. (I10)

Regarding the profession, if care quality is compromised, society's opinion on nursing care and, consequently, on nursing as a profession is negative, impacting "the nurse, the team, and the profession" (I4).

Regarding the Typology of MNC, nurses reported omissions relating to the affective/relational dimension of caring, such as *communicating with the patient/family* and *educating the patient/family*, and healthcare delivery support activities, such as *keeping nursing records* or *developing or updating care plans (CPs)*.

Another dimension with MNC was the technical component, namely *oral hygiene care*, *body hygiene care*, *positioning*, *lifting and ambulation, and feeding*. Finally, within the scope of interdependent activities, MNC occurred in the *monitoring of vital signs/capillary blood glucose*, *medication identification and administration within 30 minutes after prescription,* and *medical device maintenance procedures*.

Participants reported that communicating with the patient/family is a MNC due to unavailability caused by multiple factors that conditions the nurses' performance and due to the lack of visibility of this activity, making it difficult for others to judge. At this level, nurses also reported carrying out technical procedures without previously informing and preparing the patient: "sometimes we just carry out the procedures and don't explain what we're doing." (I8). Care delivery is not negotiated, and when there is communication, it is minimal, unidirectional, or with short answers to maximize the nurse's time: "The communication with the patient and their family is what no one sees and is left undone" (I1; I4; I6); "we stick communication with the patient to the minimum necessary: one-way or two-way communication if we want to obtain some information, we must ask simple and direct questions because we can't waste time and we have to move on to the next patient" (I7).

Nurses also perceived patient/family education as MNC, not because it is not performed, but because the learning/teaching conditions are not suitable, namely the lack of time to clarify doubts and validate and/or reinforce the information transmitted, which impairs the quality of care:

> we often find the time to educate the patient, but from the amount of information that we give them, they're going to understand half of it or nothing at all. And we often don't have the time to reinforce it throughout their hospital stay. It's done and it's over, period. We often do it because we know we have to, that it's important for the patient, but it's all done in a hurry . . . we don't omit, but we don't do it right. (I4)

Nurses also revealed that when this activity is properly performed, it can compromise the development of other interventions because they take a long time to perform.

Nurses recognized that they sometimes carried out activities for the patients, without promoting their autonomy when they are still capable of performing them on their own: "It's faster if I do it myself rather than allowing the patient to do it" (I3).

Still regarding MNC, the interviewees recognized that the transition from hospital to home may be compromised if "the family is not integrated in the care context" (I7) or if the family/informal caregiver is not empowered to take on this role. In this transition process, they considered that they should prescribe certain aspects of care to minimize the likelihood of them not being performed and becoming MNC, "for them not to become MNC at home" (I5).

They also reported that if they trained the family/informal caregiver to perform some care activities during the patient's hospital stay, they (the professionals) would have more time to carry out other care activities and, at the same time, they would be preparing the family/informal caregiver to care for the patient at home.

The interviewed nurses perceived nursing record keeping as a time-consuming activity. Nurses preferred direct contact with the patient, so it was reported as the last thing they do. Although they acknowledged the importance of proper record keeping, it is sometimes left undone: "Record keeping is the last thing I do. If I must leave something behind, it will certainly be the nursing records" (I4).

The interviewed nurses described the process of keeping records in digital platforms as complex and reported that the lack of nursing records does not immediately affect the patient's health status, "the records have no immediate effects on the patient . . . They may harm them in the long term but not in the short term" (I10). Other participants said that they keep the records for legal protection, "I keep them [records] for my protection because we know that they're important and that we must do them, I would not leave them undone for a matter of legal protection" (I4).

Moreover, the development or update of CPs was not a major priority for the interviewed nurses, although they recognized that the lack of update can put "care quality and intervention effectiveness at risk" (I1). The 24-hour care plan is reported as a time-consuming administrative requirement that is not put into practice or suitable for staffing levels or nurse-patient ratios, considering the translation into hours of required care. According to the participants, "updating the CP is not a top priority, is it?" (I1; I2; I4) and "regarding the CP update, what you see is that you're doing it, but you don't get any feedback: it can show 100 negative hours, but the ratio will always be the same" (I7).

Regarding MNC in hygiene, oral hygiene is often "left to the background" (I7), even though nurses consider it essential, particularly in patients with head and neck tumors, "we don't do oral care, which should be fundamental in our unit" (I5). This omission occurs mainly during the afternoon shift because "in the afternoons there isn't enough time to perform it" (I5) as it is a time-consuming aspect of care, particularly in patients who do not collaborate or do not want to wash their mouth every day and after meals: "you can take 5 or 10 minutes to perform oral hygiene on a patient" (I7).

Considering body hygiene, participants suggested that "many nurses are not with their patients during bath time" (I10). Due to the need to redefine their activities, nurses admitted that they omit hygiene care and that they are even criticized for this decision: "I'd rather not give a bath than not to teach someone who needs to be taught, but I know that I'm criticized for it" (I3). Nevertheless, other nurses also reported that they try not to omit hygiene care by performing partial hygiene care, thus ensuring minimal patient comfort: "I leave general hygiene out, I identify the patients for whom it is essential and perform partial hygiene care on the others" (I5); "I try to perform hygiene care . . . Even if only partially . . . so that the patient can feel minimally comfortable" (I9).

Participants perceived positioning and repositioning as MNC because the recorded positionings are not performed. This situation occurs because nurses consider that patients have aid devices for pressure ulcer prevention or decide to respect the patient's sleep and rest, not waking them to position them. Nurses believe that this omission benefits the patient: "repositioning is not performed: we follow a sequence of positioning steps that are not really performed; we record positionings without changing the decubitus position" (I1); "positioning and repositioning are omitted due to the existence of viscoelastic mattresses, and sometimes the patients are not positioned as often as they should . . . they needed more" (I7; I10); "if the patient is sleeping, I don't wake him up . . . and it's for the patient's benefit" (I3; I9).

The interviewees also reported patient lifting and ambulation as MNC. They found important to lift patients "to promote their independence, but we don't do it . . . We don't have the time!" (I1). The lack of recognition and valorization of these procedures by their superiors and of nurses' available time and physical conditions are some of the reasons for the omission of these care procedures: "Why should I walk 0.5km with the patient along the corridor if it's not going to change anything?! I'm going to receive the same recognition . . . Some people think like that. Let me just sit here." (I4); "If my back hurts, I'm not going to lift the patient, am I? And it becomes MNC." (I10).

Still, regarding these care activities, omission occurs when they are performed but not recorded or are not performed, although planned, and recorded as performed: "Sometimes you lift the patients and the records say that they're in supine position and the opposite is also true" (I2).

Nurses reported that patient feeding is omitted to the detriment of other activities. According to them, "they don't feed the patients" (I10) or do not encourage them to feed themselves: "we leave feeding to the nursing auxiliary staff . . . so we can do other things" (I3); "we do not encourage patients to have supper . . . this omission goes to the point that we don't have a feeding schedule at 10 p.m." (I5).

They admitted they provide "little water to patients... we only hydrate them a little. I've noticed unused cups or bottles with the same volume of water overnight" (I9).

The interviewed nurses also mentioned the monitoring of vital signs/ capillary blood glucose as MNC. They per-

form it based on their judgment of the need to evaluate a given parameter. Thus, considering the shift's expected workload and the patient's assessment, the nurses decide whether to measure the vital signs and what parameter/s they should evaluate.

However, they highlighted that some colleagues assess the vital signs in every shift, even when patients are stable, and that others record a parameter they did not assess, whether vital signs or capillary blood glucose: "sometimes we don't assess for fear of the result because we may have to trigger other interventions that will require even more work" (I10).

Regarding pain assessment, although nurses reported that they favor this vital sign, they acknowledged that they do not always perform it correctly as they do not ask the patient to quantify their pain on a scale from 0 to 10: "We don't ask the patient . . . at least I don't hear it, nor do I do it . . . 'On a scale from 0 to 10, how do you rate your pain?', we assess pain incorrectly even though we have scales" (I6).

The identification and administration of medication within 30 minutes after its prescription is MNC if medication is not administered at the scheduled time. Participants reported that "we often change the schedule [of medication administration] as a matter of patient comfort and to our convenience" (I3; I8).

They also reported that this MNC can occur if the nurse uses a therapeutic plan that is outdated in relation to the online prescription, if the administered medication is not identified, or if the nurse does not empower the patient to make a decision regarding their medication: "The medication delivered through infusion isn't often identified (I1); "many people prepare the medication based on a printed kardex that may be outdated" (I6); "we even forget that the patient can refuse the medication that we often administer without explaining what it is or what it does" (I6).

Medical device maintenance procedures are also reported as MNC due to the lack of optimization of medical devices or lack of knowledge about handling them. When this aspect of care is not planned, it will not be performed. Also, whenever there are new devices that are not usually used in the unit, the lack of training or knowledge about them can lead to difficulties in working with them: "there are general procedures regarding medical devices, but we often don't even realize that we should do this planning, so they remain undone, and I too . . . it also happens to me: catheters, tubes, tracheostomies" (I6).

"And we often have new devices, for example chest tubes, new drainage systems, and we don't know how to work with them" (I9).

Discussion

Nurses define MNC as planned nursing care that are not performed either partially or completely for various reasons and, considering Jones et al.'s definition (2015) of MNC, it is possible to conclude that the participants were aware of the issue under analysis.

This study identified the nursing care that are omitted in clinical practice. The following aspects of care were reported as MNC: feeding; body hygiene, including oral hygiene; positioning; lifting and ambulation; nursing record keeping; development and update of CPs; patient/family education; patient/family communication; and monitoring of vital signs/capillary blood glucose. These aspects of care are also observed in international studies included in the integrative literature review by Jones et al. (2015) and in the study by Braga et al. (2018) in Portugal. In the literature consulted, it is the first time that medical device maintenance procedures and the identification of prescribed medication in perfusion are referred to as MNC, thus providing new knowledge to the mapping of MNC.

The use of semi-structured interviews for collecting data allowed for a more in-depth knowledge of this issue concerning the methodologies used in quantitative studies, revealing a more diversified omission of care, which is in line with Reham et al. (2017) who found significant differences in MNC while analyzing different research designs and data collection tools (Dehghan-Nayeri et al., 2018).

The nurses recognized that missed care have an impact on the patient, the nurse, and the profession and may worsen the patient's health status (healthcare-associated infections, pressure ulcers, or lack of mobility), weigh on the nurses' conscience, or make society develop a negative opinion about the profession.

In a literature review, Recio-Saucedo et al. (2018) had already reported these impacts by pointing out that MNC promoted higher rates of mortality, infections, and falls, as well as more post-discharge complications and lower patient satisfaction with care, thus compromising the nurses' well-being and society's view of nursing.

MNC can compromise patient safety not only during the hospitalization process but also at home if they are not performed by the family (Azevedo & Sousa, 2012).

The analysis of MNC reported by nurses shows that the ethical dimension of care is compromised because nurses have a moral obligation to deliver safe, quality care and protect patients from harm. According to Vryonides et al. (2016), an institution's ethical climate may influence the nurses' ability to sustain their moral identity.

Kearns (2019) considers that the decision-making process that leads to omissions of nursing care should be carefully reflected upon; nurses may or may not be held ethically responsible depending on the reason for this omission.

Identifying MNC is an important step towards unveiling the knowledge of this phenomenon. Studies should be conducted with more representative samples to obtain the greatest possible amount of information on this issue and, thus, lead to changes in clinical practices. Other sources of information (IT systems, patients, or others) should also be used to compare the data obtained from those involved in the care process, as well as other data collection techniques, particularly the observation of care delivery.

It is essential to analyze the nursing work environment, the structure variables (human and material resources, characteristics of the physical environment, service orga-

nization), and the process variables (technical aspects of diagnosis and therapy, relationship between professionals and patients, inherent behaviors, and ethics) that can lead to the omission of care (Smith et al., 2017).

Conclusion

This study identified nurses' perceptions of MNC in the setting under analysis.

These omissions are consistent with the literature and cover nurses' autonomous and interdependent activities.

Regarding their autonomous activities, the following MNC were reported: patient/family communication, patient/family education, nursing record keeping, development and update of CPs, feeding, oral hygiene, body hygiene, positioning, and lifting and ambulation.

Regarding interdependent activities, the following MNC were reported: monitoring of vital signs/capillary blood glucose, identification and administration of medication within 30 minutes after its prescription, and medical device maintenance procedures.

Based on the researchers' knowledge and the literature search, it is the first time that the identification of the prescribed infusion therapy and medical device maintenance procedures are referred to as MNC.

After mapping MNC, the contextual knowledge obtained was relevant for investigating the reasons underlying the omission of care to ensure that the basic standards of nursing care are met. This way, it will be possible to reduce the incidence of MNC, improve the quality of care, and increase the satisfaction of all those involved in the care process.

The development of qualitative studies exclusively in oncological settings would deliver a better characterization of this issue in settings underexplored in international studies.

Author contributions

Conceptualization: Paiva, I., Amaral, A., Moreira, I.
Data curation: Paiva, I., Moreira, I.
Methodology: Paiva, I., Amaral, A., Moreira, I.
Writing – original draft: Paiva, I.
Writing – review & editing: Paiva, I., Moreira, I.

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