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RESEARCH ARTICLE (ORIGINAL)

Missed nursing care in oncology: exploring the problem of a Portuguese context

Cuidados de enfermagem omissos em oncologia: explorar o problema de um contexto português

Cuidados de enfermería omitidos en oncología: explorando el problema en un contexto portugués

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Abstract
Background: Missed nursing care (MNC) compromises health care quality and patient safety. The contextual knowledge of the reasons for MNC allows redesigning nurses' practices and improving the satisfaction of those involved in the care process.
Objective: To identify the reasons for MNC perceived by nurses of an oncology hospital.
Methodology: Exploratory, descriptive, cross-sectional study with a qualitative approach based on assumptions of the case study research. The sample consisting of 10 nurses with application of semi-structured interviews. All ethical assumptions were met.
Results: The reasons for MNC were associated with the context – Scarcity of resources and Organizational culture – and the nurse – Negligence/devaluation, Willful misconduct, and Beliefs.
Conclusion: The knowledge produced can contribute to the implementation of specific guidelines directed at the identified reasons for reducing MNC and, consequently, improving health care quality.

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

Resumo
Enquadramento: Os cuidados de enfermagem omissos (CEO) comprometem a qualidade dos cuidados prestados e a segurança do doente. O conhecimento contextual das razões subjacentes aos CEO permite redesenhar as práticas dos enfermeiros e melhorar a satisfação dos intervenientes no processo de cuidar.
Objetivo: Identificar as razões percecionadas pelos enfermeiros de um hospital de oncologia como promotoras de CEO.
Metodologia: Estudo exploratório, descritivo, transversal de natureza qualitativa assente em pressupostos do estudo caso. Amostra de meio, constituída por 10 enfermeiros com aplicação de entrevista semiestruturada. Foram cumpridos os pressupostos éticos.
Resultados: As razões identificadas para a ocorrência de CEO relacionaram-se com o contexto – Escassez de recursos e a Cultura organizacional – e com o enfermeiro –Negligência/desvalorização, o Dolo e as Crenças.
Conclusão: Com o conhecimento produzido, podem-se implementar diretrizes específicas minimizadoras de CEO direcionadas às razões identificadas e consequentemente garantir a melhoria da qualidade dos cuidados prestados.

Palavras-chave: cuidados de enfermagem omissos; segurança do paciente; oncologia; gestão da qualidade

Resumen
Marco contextual: Los cuidados de enfermería omitidos (CEO) comprometen la calidad de los cuidados y la seguridad del paciente. El conocimiento contextual de las razones que subyacen a los CEO permite rediseñar las prácticas de los enfermeros y mejorar la satisfacción de los implicados en el proceso de atención.
Objetivo: Identificar las razones percibidas por los enfermeros de un hospital oncológico como promotoras de CEO.
Metodología: Estudio exploratorio, descriptivo, transversal, de naturaleza cualitativa, basado en la hipótesis del estudio de casos. Se utilizó una muestra de 10 enfermeros y se aplicó la entrevista semiestructurada. Se cumplieron todos los presupuestos éticos.
Resultados: Las razones identificadas por las que ocurren los CEO estaban relacionadas con el contexto –Escasez de recursos y Cultura organizativa– y con el enfermero –Negligencia/desvalorización, Duelo y Creencias.
Conclusión: Con los conocimientos producidos se pueden implementar directrices específicas para minimizar los CEO, dirigidas a las razones identificadas y, en consecuencia, garantizar la mejora de la calidad de los cuidados prestados.

Palabras-clave: cuidados de enfermería omitidos; seguridad del paciente; oncología médica; gestión de la calidad

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Introduction

The growing concern with missed nursing care (MNC) has transformed this phenomenon into a strong indicator of health care quality (Kalisch et al., 2009; Santos, 2018).
The factors contributing to the occurrence of incidents that influence patient safety and the omission of nursing care may cause physical and emotional harm to the patient and family and damage the reputation and economy of healthcare services, for which reaon they must be controlled (Despacho n.º 1400-A/2015).
The in-depth characterization of MNC is essential to understand why it occurs and develop strategies to minimize it (Amaral, 2014).
Santos (2018) found the following MNC: "comfort/talk with patients", "develop or update care plans", "teach/counsel patients and family", "adequately document nursing care", "oral hygiene", and "adequate patient surveillance" as MNC. Therefore, based on these results, this study aims to identify the reasons for MNC perceived by nurses of an oncology hospital.

Background

MNC is any required patient care omitted or delayed in nurses' everyday practice (Kalisch et al., 2009). Jones, Hamilton, and Murry revised this definition in 2015 and added the term *unfinished care*, makes the difference between the omission of care from the nurse's rationalization process.
To better understand this phenomenon, it is important to identify MNC and analyze the decision-making process that makes nurses prioritize care.
In a study conducted in an oncology institution, Paiva (2019) identified the following MNC: in the context of autonomous MNC in the relational dimension of caring ("communicating with the patient/family" and "teaching the patient and family"), in the instrumental dimension of caring ("feeding/hydration", "oral hygiene", "body hygiene", "positioning", and "lifting and ambulation"), and in the activities supporting care delivery ("documenting nursing care" and "elaborating or updating care plans"), as well as in the context of interdependent MNC such as "monitoring vital signs/capillary blood glucose", "identifying and administering medication up to 30 minutes after its prescription", and "maintenance care with medical devices" (Paiva, 2019).
The literature identifies multiple predictors of MNC that may be associated with the patient and the family, the health care institution, and the nurse (Bragadóttir et al., 2016; Cho et al., 2017; Dehghan-Nayeri et al., 2015; Kalisch et al., 2014; Papastavrou et al., 2016).
Concerning the patient and the family, the sudden worsening of patients' clinical condition, the complexity of care, the improved knowledge about their rights, and the unexpected increase in workload emerge as predictors of MNC (Rehem et al., 2017).
At this level, the interruptions experienced by nurses during their shifts also influence health care organization and delivery (Cho et al., 2017; Kalisch et al., 2014).
For Ausserhofer et al. (2014), the omission of nursing care can be associated with the health care institution, namely with problems in the management of material resources (delay or disruption in the supply of medications or unavailable/inadequate materials and equipment for care delivery; Moreno-Monsiváis et al., 2015).
Several studies have identified the allocation of nurses and other human resources as a cross-cutting factor, namely the literature review conducted by Jones et al. (2015).
According to Ausserhofer et al. (2014) and Dehghan-Nayeri et al. (2015), the lack of teamwork and a poor hospital safety climate suggest that the philosophy of care delivery, the management problems, and the inadequate leadership styles create an environment conducive to MNC. Moreover, the lack of quality improvement policies and healthy intraprofessional and interdisciplinary relationships promotes the occurrence of MNC due to organizational communication deficits (Cho et al., 2017).
The nurse should also be seen as a factor promoting MNC mostly because professional dissatisfaction, lack of nurse retention and intention to leave, high absenteeism rates, and lack of academic training are factors influencing MNC (Ausserhofer et al., 2014).
Nurses' interests and sense of morality may also influence the occurrence of MNC to the extent that nurses prioritize care related to physical tasks and those resulting from interdependent actions (Ausserhofer et al., 2014; Bragadóttir et al., 2016).
Identifying the factors associated with MNC is crucial to implement strategies for mitigating this problem (Dehghan-Nayeri et al., 2015).

Research question

What are the reasons for MNC perceived by nurses of an oncology hospital?

Methodology

An exploratory, descriptive, and cross-sectional study was conducted with a qualitative approach based on assumptions of the case study research. It was approved by the health unit's research and ethics committee (Opinion no. TI 12/2020).
The target population was composed of the nurses who participated in the previous research study conducted by Santos (2018; n = 63). The sample consisted of the nurses who had been working in the inpatient units of medical specialties of an oncology institution for more than one year.
A milieu sampling technique was used. The sample consisted of purposefully selected nurses because of their greater accessibility to the researcher and their interest in participating in the study.
A self-administered questionnaire and a semi-structured interview script were designed. For the participants' socio-demographic and professional characterization, the questionnaire included the variables of gender, age, length of professional experience in the unit, academic and professional qualifications, workload, and type of schedule.
The script was pre-tested and consisted of three sections: contextualization of the research study, interview structure, and exploration of the topic under analysis).
Data were collected between September 5 and October 9, 2018. The principal investigator conducted the interviews in a venue with the necessary requirements, lasting, on average, 50 minutes.
The participants were mostly women (80%), with a mean ($\bar{x}$) age of 37.9 years, a standard deviation (*SD*) of 6.33 years, a minimum of 27 years, and a maximum of 49 years.

The mean length of professional experience was 14.9 years (*SD* = 6.03), with a minimum of 4 and a maximum of 23 years. The participants had been working in the services under analysis for 11.9 years (*SD* = 5.5), with a minimum of 2 and a maximum of 17 years.

Concerning their academic qualifications, 20% hold a Master's degree, and 20% hold the title of "specialist nurse" awarded by the *Ordem dos Enfermeiros* (Portuguese nursing and midwifery regulator).

All participants worked in shifts, and 70% reported working, on average, five more hours per week than the contracted hours.

After each interview, the audio-recorded data were transcribed and analyzed based on Bardin's content analysis technique (pre-analysis, material exploration, and data treatment [inference and interpretation]). Questionnaire data were analyzed using descriptive statistics, and data saturation was reached at the 10th interview.

The ethical principles inherent to the nature of this study were ensured, and the interview recordings and transcripts, the consent forms, and the completed questionnaires were destroyed.

Results

The content analysis process revealed the following reasons for MNC: Negligence/Devaluation, Willful misconduct, Beliefs, Scarcity of resources, and Organizational culture.

For the interviewees, Negligence/Devaluation occurs when they prioritize the delivery of interdependent nursing care over autonomous care. In their opinion, this situation happens because the omission of autonomous care is more difficult to objectify, although they recognize that they can add value to nursing in this area and "make a difference" (N9), "the care that we leave undone is more difficult to operationalize. For example, the emotional support provided to a patient is barely operationalizable... the truth is that we prevaricate in communication and not in medication" (N4; N5; N6; N10).

Still in this category, delegating nurses' tasks is identified as a response to "reluctance toward the other person's body (N10) because this care is seen as "less decent" (N10) or because nurses have to redefine priorities throughout the workday. Thus, they delegate activities to assistants, which "leads to care felt undone (N6) as these workers have "have no adequate nor sufficient training" (N8) to deliver care: "Many nurses delegate feeding and hygiene tasks to assistants ineffectively" (N5; N6; N10).

Another reason for MNC is Willful misconduct. Participants reported being aware that sometimes they do not deliver some aspects of care "due to sloppiness… sloppiness because it takes a lot of work" (N8). The nurses' quotes reveal a sense of morality and an intention not to perform certain aspects of care, especially those that "require time, attention, and dedication" (N7) given the increased workload, either due to the nurses' physical conditions or personal reasons: "It's about not doing it because you don't feel like doing it... and we know that this also happens in our practice" (N3; N4); "If I have the time and I feel like doing it… I sit down and talk to the patient. I mean, talking or delivering any other aspect of care" (N10); "Arriving late, still getting dressed... having breakfast… then spending time on the cellphone… and that's it… assiduity in care is already compromised" (N10).

The nurses' Beliefs emerged from the analysis of the interviews. It is based on their convictions that they decide whether or not to perform a given aspect of care as it may "no longer be worth it [providing a certain aspect of care]" (N3). They may omit an aspect of care that, in their opinion, has less impact on the patient's health status or is less important for the patient given their clinical status, rather than taking into account the patients' opinion about what is less important for them:

We always end up omitting care that we think is less important; it's not that it's less important for the patient, but, at that moment, we have to make a choice, and we choose those aspects of care that we think are less important and do less harm. (N4; N5; N9)

The Scarcity of human and material resources is another reason for MNC that emerged from this study.

The interviewed nurses reported the small number of "nurses and assistants" (N2) and the work overload as aspects that jeopardize health care quality and may lead to MNC: "MNC occurs exactly due to an excessive workload, a high number of patients under your care, the number of hours of care per nurse" (N4).

The work overload is associated with the lack of time available to meet the daily demands, which makes them "hurry things up" (N3) because everything must be done at the end of the work shift, and they "don't have enough time to reflect on care" (N6). However, they recognize that lack of time is a common excuse to justify MNC, "it's a great excuse" (N7): "it's a determining factor for MNC, but it's not the only one, and we cannot blame others" (N10).

The participants mentioned that the complexity of the care provided to patients/families, both due to the patient's clinical condition and the doubts raised by the patients/families about the situation, leads to the nurses' emotional and physical exhaustion: "the complexity of the patients and families is a great burden on us and, of course, we cannot escape that" (N1).

For the interviewed nurses, the presence of family members during hospitalization and the need for them to also receive care "exhausts us and takes a lot of time away from care delivery, even from other patients" (N2): "the more independent patients are more neglected because they require less attention than acute patients" (N7).

According to the nurses, their fatigue, the inability to meet the care needs, the lack of motivation, and the lack of recognition for their work are factors that contribute to MNC: "the older staff are tired, and sometimes we slack off" (N2; N4); "We work, and we like to see our work being recognized by patients and families, and it also affects us when that doesn't happen" (N2; N3; N4); "Many nurses are not motivated due to economic factors" (N1; N2; N10).

Participants emphasize that the time spent by nurse auditors in assessing nursing outcomes is necessary for the delivery of direct patient care: "while some nurses are evaluating other nurses in the ward, there are patients who would need those nurses to receive their care" (N3).

Nurses reported that insufficient material resources, such as adaptive equipment for hygiene care or lifting, compromise the patient's comfort, which is an aspect that they prioritize. On the other hand, obsolete material resources can change care planning and make nurses spend a lot of time in care documentation: "the computer software and equipment are obsolete. The software is always lagging" (N7).

Some interviewed nurses reported that, although their service had the necessary resources to provide care, they were not properly allocated. They also mentioned that the patient's hydration should not be a MNC because it did not require any specific resources. In this case, it is not the lack of material that prevents it from being done: "Oral hydration, for example, we have everything for it: water and glasses in the patient's room. So why don't I give it to them? I don't know" (N9).

Structural conditions may also jeopardize the individualization and quality of care, which may compromise the care delivered to the patients or others: "Cold and heat... are key factors in our care" (N10); "The bathrooms are not adapted to our patients: to get into the shower, you have to lift your feet so high! The toilets are against the wall, and obese patients have difficulties sitting down. These are structural flaws" (N10).

Moreover, concerning physical spaces, the nurses highlighted the lack of a private environment that allows information confidentiality when addressing complex topics:

Often . . . you don't have a private space to talk to the patient. The physical space is also important, and I believe that people even think about communicating, but, in wards with four patients, I don't think anyone addresses complex topics. (N6)

The Organizational culture of both the ward and the institution emerged as a category that can influence the occurrence of MNC.

The institution's lack of acceptance of innovative projects developed by nurses and the lack of recognition measures by the "top managers" (N4; N5; N9), such as career unfreezing and progression, create negative feelings that compromise organizational well-being: "They don't let us try to do innovative projects or implement different things here. People don't feel like doing anything" (N7); "There should be career unfreezing and progression… economic recognition" (N2; N8; N9; N10).

The interviewees mentioned that "many lack motivation due to the leaders' role" (N10). According to them, the heads of service are absent from the ward for a long time, which conditions their perception of the nature, demand, and complexity of care, and are more focused on the processes of evaluation of the quality of care provided rather than on the management of human capital: "And if our boss knew the patients… Even to be able to distribute patients honestly and fairly among nurses" (N3; N6; N10).

The communication failures among professionals, such as the lack of teamwork and a spirit of mutual help, influence health care quality because "we plan out work only thinking about ourselves, there are no teamwork, organization, or goals to be achieved" (N1; N3).

Participants also mentioned the importance of multidisciplinary communication as a strategy for problem-solving in data management, although they recognized that collected data are not always forwarded: "If I access a set of information but don't forward it... If I do nothing, there are no criteria for reaching diagnosis" (N5; N10).

Participants also analyzed peer communication, pointing out the negative criticism toward nurses when they deliver a certain aspect of care related to their specific area of expertise: "Because if there's no rehabilitation, those who deliver rehabilitation care are criticized. In the next shift, I'll be reprimanded because I did something different" (N3).

Although participants prioritize the contact with the patient over care documentation activities, they reported that the documentation standard and the medical record system platform were "confusing and very fragmented" (N6) and that they did not meet the specificities of each context and the needs of each patient: "You read the file, and it seems that all patients are the same. You should be able to identify the patient in question… and you can't" (N10); "For the record not to be omitted, I have to open many windows to justify everything… and it's not structured based on the ward's needs, but rather on the institution's auditing needs" (N5; N9).

If nurses' "ability to deal with technology is not the same" (N4), the "constant interruptions" (N7) they experience during care documentation influence the preparation or updating of care plans because they keep "the records amidst confusion and constant requests" (N5; N9).

Discussion

The reasons identified by the participants for MNC are found in the national and international literature on this topic. Amaral (2015) had already identified the lack of resources, negligence/devaluation, and the factors related to the workplace, which are corroborated by the categories Negligence/Devaluation, Scarcity of resources, and Organizational culture. The categories Beliefs and Willful misconduct were also mentioned by Bragadóttir et al. (2016) and Chapman et al. (2016), who argued that the nurses' habits and interests/sense of morality should be considered when analyzing missed care.

Papastavrou et al. (2016) and Timmins et al. (2017) had already identified the Negligence/Devaluation of autonomous or difficult-to-objectify care over interdependent care. This situation may happen because the prescription is prepared by other professional groups, and the omission of this aspect of care is criticized, which will not occur if autonomous care is omitted because the prescriber and the practitioner are the same person and the possibility of criticism is lower.

Timmins et al. (2017) had already highlighted the lack of time available to perform all the activities planned for each shift as one factor leading to delegation. The interviewed nurses also mentioned the lack of time and the importance that they assign to care as key aspects for delegation.

Given that nurses reported that they do not always supervise or assess the performance of the task and that the Ordem dos Enfermeiros (2007) recommends that delegating nursing tasks should involve transferring activities to a competent individual who is functionally dependent on the nurse, who takes on the responsibility for the delegation, the ineffective delegation of tasks can be a key factor for MNC. In 2009, Kalisch et al. warned that ineffective task delegation was the cause of MNC.

Willful misconduct emerged as another reason for MNC, which is in line with Bragadóttir et al. (2016) and Chapman et al. (2016).

As willful misconduct is characterized by an individual's free and conscious decision to act in a certain way, in nursing practice, it is related to the omission of a certain aspect of care. At this level, willful misconduct includes the following aspects: the purpose with which the nurse decides not to deliver a certain aspect of care; the determination to check if care was intentionally ommitted

by the nurse or a mere response that led the nurse to the attitude of omission; and the nurse's level of agreement with the decision of omission and its outcomes (Decreto-Lei n.º 48/1995).
In this context, willful misconduct can be associated with the nurse's conscious definition of a goal resulting from the omission of care, the ability to determine if the omission of care was caused by the nurse or a response to the lack of available resources that influence care delivery, and how nurses identify themselves with the omission of care or critically assess the outcomes of that omission. The nurses' sense of morality is a relevant aspect to be considered when analyzing the conscious omission of care. Nurses' assess if the patient needs a care and decide, or not, to deliver that aspect of care. Nurses' continue to omit it if it leads to apparently no harm to the patient. (Bragadóttir et al., 2016).
Nurses' beliefs are another reason for MNC, in which their convictions, ideas and perceptions considered absolute and true are useful to clinical judgment and prioritization. Nurses' beliefs are built upon their views of themselves and the world, although there is no proof, rational basis, or empirical justification for them. They are influenced by external factors, the social environment, and the culture in which nurses are inserted and work (Kalisch et al., 2009). The participants decide, based on their beliefs, to perform or not to perform a certain aspect of care, which is prioritized based on their perception of what will have a greater impact on patients' health status. Kalisch et al. (2009) had already reported that nurses' beliefs influence MNC, being that the choice to perform, delay, or omit care is influenced by factors internal to the nurses, such as the health care team norms and protocols, the decision-making processes, the internal values, attitudes, and beliefs, the individual perspectives, and the habits of care omission.
The Scarcity of resources was another reason for MNC. The most common reason for MNC mentioned by the interviewed nurses was the understaffing of nurses and other professionals working with them, which is in line with Chapman et al. (2016) and Papastavrou et al. (2016). Kalisch (2014) and Cho et al. (2017) highlighted the level of demand of the patient/family for whom the nurse is responsible and the volatility of workload as reasons for MNC. The complexity of clinical situations, the increased knowledge of the patient/family about their rights, the unexpected number of patients admitted to the ward, and unplanned clinical discharge are potential reasons for MNC.
The interviewed nurses reported working five more hours per week than the contracted hours. According to Ausserhofer et al. (2014), reduced job satisfaction, increased intention to leave the profession, increased workload, and professional turnover negatively affect the delivery of quality health care.
According to Bragadóttir et al. (2016), Chapman et al. (2016), and Moreno-Monsiváis et al. (2015), the lack of material resources, namely the lack of adaptive equipment for hygiene and comfort care or lifting, computer equipment, and adequate infrastructures, leads to MNC and compromises nursing activities.
Organizational culture also emerged as a category that may influence the omission of care, which is in line with Ausserhofer et al. (2014) and Dehghan-Nayeri et al. (2015), who identified hospital culture, organizational climate, management and leadership failures, and lack of teamwork as possible reasons for MNC.
The institution's failure to welcome innovative projects and recognize the work developed by nurses generates discontent among this professional group and compromises individual and organizational well-being.
For the participants, the team leaders' leadership styles are inadequate and limit their perception of the nature, demand, and complexity of nursing care, which is in line with Dehghan-Nayeri et al. (2015).
Kalisch et al. (2009) had already highlighted communication failures among professionals as a reason for MNC. In line with Timmins et al. (2017), the interviewed nurses showed that ineffective peer communication and inadequate teamwork lead to the omission of care.
For nurses, the individual work method may be a reason for MNC to the extent that they disregard the help of others in the performance of the planned activities, which increases the burden, as Chapman et al. (2016) had concluded.
The high degree of complexity required to implement the documentation standard and the medical record system platform and the interruptions experienced by the nurses impair the effective and efficient performance of their activities. Kalisch et al. (2014) and Cho et al. (2017) had already highlighted that the interruptions by family members or other professionals influence care organization and delivery.
Performing activities that are not directly related to care makes nurses less available to patients, which may increase the incidence of MNC. Despite this, the participants prioritized the contact with the patient/family over the remaining activities supporting clinical practice, which is corroborated by Ball et al. (2014).
Data were collected during a specific time period of nurses' dissatisfaction with the government's professional development policies, which may have influenced these findings.

Conclusion

This study identified the reasons for MNC perceived by nurses. These reasons are associated with both the structure of the practice environment, namely the scarcity of resources and the organizational culture, and factors internal to the nurses, such as their negligence/devaluation of certain aspects of care, willful misconduct, and beliefs. Identifying the reasons for MNC benefits the organization and contributes to the definition of strategies to ensure that nursing care is fully delivered while ensuring patient safety.

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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