REVISTA DE ENFERMAGEM REFERÊNCIA
homepage: https://rr.esenfc.pt/rr/
ISSNe: 2182.2883

RESEARCH ARTICLE (ORIGINAL)

Nurses' perspectives on the reasons for missed care in home care settings

Cuidados omissos em contexto de cuidados domiciliários: Razões na perspetiva dos enfermeiros

Cuidados omitidos en la atención domiciliaria: Razones desde la perspectiva de los enfermeros

Maria da Conceição Saraiva da Silva Costa Bento [1]
https://orcid.org/0000-0001-8311-4537

Abel Paiva e Silva [2]
https://orcid.org/0000-0002-3362-4165

[1] Nursing School of Coimbra, Coimbra, Portugal

[2] Nursing School of Porto, Porto, Portugal

Corresponding author
Maria da Conceição Saraiva da Silva Costa Bento
E-mail: cbento@esenfc.pt

Received: 08.01.21
Accepted: 12.04.21

Abstract
Background: The delivery of care to people who live at home and depend on others for care is a complex and multidimensional reality where there are often situations of unfinished care. Few studies analyze the reasons for this phenomenon.
Objective: To explore nurses' perspectives on the reasons for missed care or care that is not provided as frequently as expected to dependent people referred to home-based long-term care teams.
Methodology: Qualitative study using the focus group technique.
Results: Nurses conceptualize unfinished care as a phenomenon that starts with a problem - lack of resources/time - associated with organizational factors and the family's conditions to assume the caregiver role, which leads to the decision to prioritize care resulting in missed or unfinished care. This process causes discomfort among nurses.
Conclusion: There is a need for a home care model that fully meets the needs.

Keywords: home nursing; nursing; patient safety; quality management

Resumo
Enquadramento: Os cuidados às pessoas dependentes no autocuidado a viver no domicílio e a sua provisão são uma realidade complexa e multidimensional, não estando em muitas situações garantida a sua completude. São escassos os estudos que analisam as razões deste fenómeno.
Objetivo: Conhecer as razões que, na perspetiva dos enfermeiros, subjazem à existência de cuidados que não são realizados ou que não são realizados com a frequência esperada às pessoas dependentes referenciadas para cuidados pelas equipas de cuidados continuados domiciliários.
Metodologia: Estudo de natureza qualitativa com recurso à técnica do *focus group*.
Resultados: Os cuidados incompletos são concetualizados pelos enfermeiros como um fenómeno que se inicia num problema - escassez de recursos/tempo - associado a fatores organizacionais e condições da família para o exercício do papel de cuidador, que leva à decisão de priorizar cuidados resultando em cuidados omissos ou incompletos. Este é um processo que gera mal-estar nos enfermeiros.
Conclusão: É necessário um modelo de cuidados domiciliários que dê resposta em completude às necessidades.

Palavras-chave: assistência domiciliar; enfermagem; segurança do paciente; gestão da qualidade

Resumen
Marco contextual: Los cuidados que se prestan a las personas dependientes en el autocuidado que viven en su domicilio es una realidad compleja y multidimensional, y en muchas situaciones no se garantiza que sea completa. Hay pocos estudios que analicen las razones de este fenómeno.
Objetivo: Conocer las razones que, desde la perspectiva de los enfermeros, subyacen a la existencia de cuidados que no se prestan o que no se prestan con la frecuencia esperada a las personas dependientes derivadas por los equipos de atención continuada a domicilio.
Metodología: Estudio cualitativo llevado a cabo mediante la técnica del grupo focal.
Resultados: Los cuidados incompletos son conceptualizados por los enfermeros como un fenómeno que parte de un problema - la falta de recursos/tiempo - asociado a factores organizativos y a las condiciones familiares para el ejercicio del papel del cuidador, lo que lleva a la decisión de priorizar los cuidados, que se traduce en una falta de cuidados omitidos o incompletos. Este es un proceso que genera malestar en los profesionales.
Conclusión: Es necesario un modelo de atención domiciliaria que satisfaga plenamente las necesidades.

Palavras-chave: atención domiciliaria de salud; enfermería; seguridad del paciente; gestión de la calidad

How to cite this article: Bento, M. C., & Silva, A. P. (2022). Nurses' perspectives on the reasons for missed care in home care settings. *Revista de Enfermagem Referência*, *6*(1), e21005. https://doi.org/10.12707/RV21005

Introduction

The phenomenon of missed nursing care has been studied in hospital settings since the early years of the 21st century (Jones et al., 2015). At an international level, 55-98% of nurses reported leaving unfinished care in acute care hospitals (Jones et al., 2015). Missed, incomplete, unfinished care, or care left undone are defined "as any aspect of required patient care that is omitted (either in part or in whole) or delayed" (Kalisch et al., 2009, p. 1510). Studies on this topic suggest that the main factors influencing the prevalence of missed care are related to the nurses' working environment, the demands associated with the patients' severity status, and the number of nurses available to provide such care (Phelan et al., 2018a). Only a few studies have explored community-based nursing care and even fewer have analyzed the phenomenon in home care settings (Sworn & Booth, 2020).

This study aims to explore nurses' perspectives on the reasons for missed care or care that is not provided as frequently as expected to dependent people referred to home-based long-term care teams.

Background

Rationing and prioritizing care (Schubert et al., 2008), tasks left undone (Sochalski, 2004), incomplete care (Jones et al., 2015), missed care (Phelan et al., 2018b), or omitted care (Kalisch et al, 2009) are all terms for required nursing care that is omitted (either in part or in whole), not provided as planned, or significantly delayed (Kalisch et al., 2009). These issues have been widely explored in hospital settings and associated with negative patient outcomes (Jones et al., 2015; Kalisch et al., 2009). In a literature review, Jones et al. (2015) found a high prevalence of care left undone by nurses (55-98%). In Ireland, Phelan and collaborators (2018b) conducted the only study found on missed care in community settings. The researchers surveyed a representative sample of nurses working in community settings about whether they missed care and what type of care they left undone as part of their job responsibilities in clinical practice. They concluded that missed care is also a significant phenomenon in community nursing. Concerning the areas of care related to home care nursing, the respondents reported 50% of missed care. More studies are needed to better understand this phenomenon outside of hospital settings, namely in home care settings. The gold standard to use in these studies for estimating unfinished care is direct observation (Sworn & Booth, 2020).

In Portugal, home-based long-term care is provided by the National Long-Term Care Network, through the Integrated Lon-Term Care Teams (*Equipas de Cuidados Continuados Integrados* - ECCI), which are integrated in the Community Care Teams (*Equipas de Cuidados na Comunidade*) of the Health Care Clusters (*Agrupamentos de Centros de Saúde* - ACES). The law in force establishes that access to this type of care is universal in Portugal (Decree-Law 101/2006 of June 6, 2006). There is growing consensus that the response in long-term care should prioritize home and community-based care to keep people who depend on others for care or at a greater risk of transitioning to dependency in their homes, whenever the health care and social support necessary for maintaining their well-being and quality of life can be ensured through home care services (Cylus et al., 2019).

Research question

What are nurses' perspectives on the reasons for missed care or care that is not provided as frequently as expected to dependent people referred to home-based long-term care teams?

Methodology

A qualitative methodological approach was used to explore nurses' perspectives given that it is the recommended approach to understand "what they are experiencing, how they interpret their experiences, and how they themselves structure the social world in which they live" (Psathas, 1974, cited by Bogdan & Biklen, 1994, p. 51). The focus group technique was used to collect data because it allows seeking the meaning and understanding of complex social phenomena (Galego & Gomes, 2005), exploring the cause-and-effect relationship, and clarifying unusual findings (Galego & Gomes, 2005). This research stage was organized based on the phases underlying the implementation of a focus group proposed by Silva and collaborators (2014): planning; preparation; moderation; and data analysis. The purpose of the focus group was to explore nurses' perspectives on the reasons for missed care or care that is not provided as frequently as expected to dependent people referred to ECCI. The inclusion criteria for the focus group were being a nurse in one of the home care teams of the ACES where the previous quantitative study that found missed care took place (proportion of care actually provided compared to planned care 33%); having been responsible for delivering care to the dependent people who participated in that study; giving their informed consent to participate; and volunteering to participate. All nurses eligible to participate in the study were contacted by phone and received an email invitation informing them of the study objectives and the rules of participation, including the estimated duration of the study and the possibility of withdrawing during the interview, and requesting confirmation of participation. The group consisted of 12 nurses, one from each team. One of the teams was not part of the study because the only nurse in the team was unable to participate on the day and time of the interview. The interview took place on 26 October 2020 and lasted three and a half hours. The researcher moderated the interview, with the help of two other researchers who managed the recording procedures, took notes, and provided support in any logistical issues. Participants were informed about the study objectives and the rules of participation. The interview

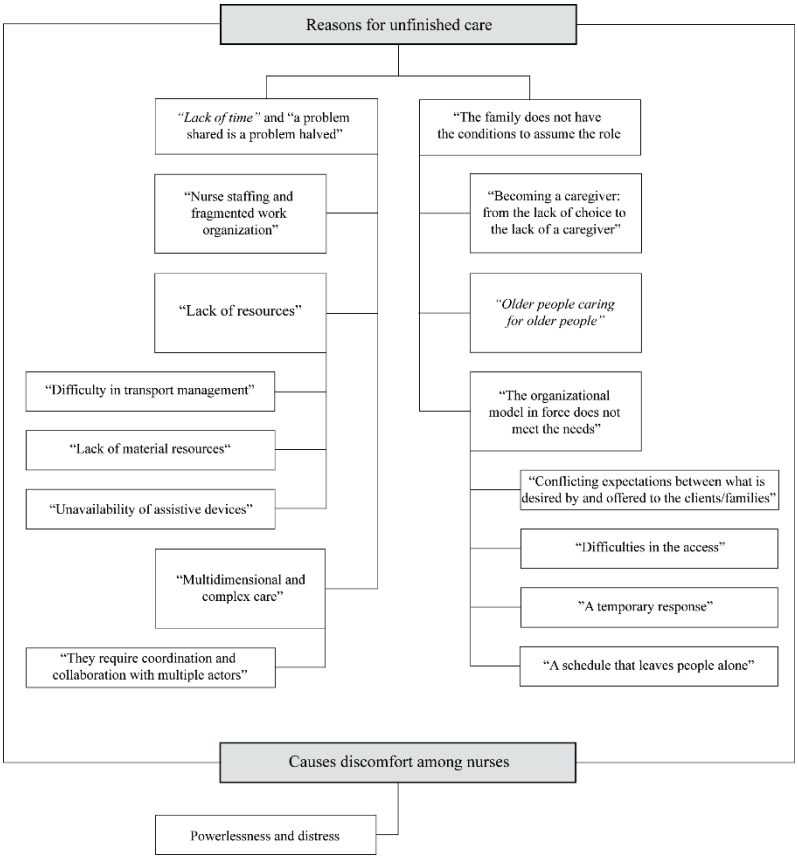
started with the central question: What are the reasons for missed/unfinished care?
The interviews were then transcribed, and data were processed and analyzed using the content analysis technique. The sequential process of analysis proposed by Strauss and Corbin (2008) was implemented. Data were classified, segmented, and preliminarily identified. Then the texts were reread, compared, and grouped into categories based on similarities and differences to identify units of analysis within the larger units and create a subsystem of codes corresponding to the subcategories. To interpret and draw conclusions from the data, the information was organized into two-dimensional matrices, regrouping the data according to the nature of the relationship between the various categories and subcategories (Strauss & Corbin, 2008). Finally, the theoretical text was written based on the analytical categories that answer the initial question: "What are the reasons for missed/unfinished care in home care?"
The study received full ethical approval from the Ethics Committee of the Health Sciences Research Unit: Nursing (Opinion no. 546/01-2019) and the Ethics Committee for Health of the aforementioned Regional Health Administration of the Center, S.A. The nurses voluntarily accepted to participate in the focus group, the interview was transcribed and anonymized, and both the transcription and the matrix of categories were validated. All ethical procedures related to research involving human beings were followed in all research stages.

Results

The study participants were 12 nurses from home-based long-term care teams of an ACES in the central region of Portugal (23% of the nurses who integrate the teams), 83.3% of whom were women. All of them were specialists in rehabilitation nursing and had more than 10 years of professional experience.
Two major themes emerged from the nurses' interviews: one main theme - Reasons for unfinished care - and a second theme - Unfinished care, a process that causes discomfort among nurses.
Figure 1 summarizes the results.

Figure 1

Synthesis of the results of content analysis



Reasons for missed or unfinished nursing care

The existence of unfinished care, that is, required care that is not provided or is left undone because it is not delivered with the necessary frequency and continuity is a reality that the participating nurses are familiar with, distressed by, and do not hide. Given that it is impossible to present all the findings, below are the most relevant ones.

There are multiple and varied reasons for not being able to implement the care plans that they consider necessary. They can be grouped into reasons related to organization-related issues, such as the lack of time, which is a key factor around which the other dimensions gravitate - here it is included in the category "Lack of time and 'a problem shared is a problem halved'" - and those related to the continuity of care that the family is expected to ensure, which gave rise to the category "The family does not have the conditions to assume the role".

Lack of time and "'a problem shared is a problem halved'"

Concerning the first group of reasons for nurses to lack the time necessary to ensure the delivery of all aspects of care and be forced to set priorities, the following aspects were found: inadequate nurse staffing and fragmented work organization; the lack of resources; and the complexity of care required by the health conditions of dependent people, which requires an often difficult set of individual actions and collaboration with others that take the time that nurses do not have. Nurses conceptualize unfinished care as a phenomenon that starts with a problem - the lack of resources/time - followed by a process in which they have to make a clinical decision to prioritize care, resulting in unfinished care/care left undone.

Inadequate nurse staffing and fragmented work organization

The nurses reported that the reasons leading to a decrease in the number of visits, lower frequency of care, and the need to prioritize focuses of attention and interventions are associated, on the one hand, with nurse understaffing and inadequate nurse-patient ratios and, on the other hand, the fragmentation and dispersion of nurses' work across other activities, projects, and home care. The insufficient amount of time to meet the needs of dependent people and their caregivers is also distributed to other activities. "In the ECCI of Y, there are 10 patients. We are two nurses, none of us can be allocated to the ECCI full-time because we also have to develop all the other activities of the range of services of the UCC [Long-Term Care Unit]" (Nurse C).

Lack of resources

The nurses reported the lack of resources necessary for the delivery of care and the difficulties in accessing them as another factor influencing unfinished care. The following aspects were highlighted: difficulties in transport management; lack of material resources; need to adapt; and unavailability of assistive devices.

The problem of managing and coordinating the transportation needed to go to people's homes emerged very often in the nurses' interviews: "then, transport, managing the transport between the various possible municipalities, it's a major headache" (Nurse D).

Nurses also talk about the lack of clinical material, devices that facilitate access to clinical information and the documentation of care where they are provided, medical devices, technical aids, and assistive products.

> In terms of difficulties . . . I think resources are - if we have things as simple as physical agents, for example, a heat plaster - it doesn't exist, an oximeter - it doesn't exist, … we don't have an aspirator. It's very complicated . . . We just don't have. And it's something that leaves us ... with a feeling of uselessness, I even identify the problem, I even know what the problem is, but . . . And then the patients go to the emergency room. (Nurse D)

The nurses reported that the unavailability of devices (equipment, instruments, technology, and software) for preventing, compensating, monitoring, assessing, or counteracting any impairment, activity limitation, and participation restriction is a factor influencing unfinished care. They attribute the difficulties in accessing these devices to issues related to their prescription and the bureaucracy in accessing them.

Given the lack of resources, the nurses reported a permanent effort to adapt to this reality. They have to improvise practices and work tools and systematically adjust their formal knowledge in clinical practice:

> Then I also experience this lack of material that my colleagues have also talked about. I confess that when I arrived here at the ECCI ... what did I have to work with? My hands and my knowledge, but I didn't have a pedal exerciser, an oximeter . . . I had some crutches and a walker. And so it's hard! Then you end up having a lot of imagination, which I think is what helps us. A fertile imagination to try to adapt the techniques to our contexts and our realities. (Nurse G)

Multidimensional and complex care

The interviewed nurses also reported that the complex and multidimensional nature of home health care for people who depend on others for care also contributes to unfinished care, namely the high level of dependency; their health condition with multiple comorbidities; the majority of them and their caregivers were part of the old or very-old age groups and were very vulnerable and frail; the nature of the context where care is provided - patients' homes - where nurses are "visitors"; the relational nature of the necessary care delivery, which requires relationships with at least one relational triad - nurse, patient, family member, caregiver, all of them experiencing processes of transition and adaptation.

The complexity and multidimensionality of the delivery of care to dependent people require the participation of multidisciplinary and multiprofessional teams and collaborative work that is informally assumed by the nurses, but which is not without difficulties. The nurses reported "the lack of a multidisciplinary team": "Besides,

we believe that the lack of a multidisciplinary team is a crucial factor for the lack of implementation of the care plan required by the patient" (Nurse F).
Nurses also described how they develop the liaison/collaborative work among the different professionals and between the people and the resources.
Nurses identified the lack of formal collaboration as a problem and mentioned that informal collaboration depends on each person and is sometimes difficult and time-consuming, thus compromising the continuity of care.

The family does not have the conditions to assume the role

The second group of reasons emphasized in the nurses' interviews to explain the existence of missed care is often related to the fact that the family, particularly the members who take on the role of caregivers, lack the conditions to assume this role. The data from this category were grouped into three subcategories: "becoming a caregiver: from the lack of choice to the lack of a caregiver", "older people caring for older people", and "the organizational model in force does not meet the needs".

Becoming a caregiver: from the lack of choice to the lack of a caregiver

In the nurses' reflection about the reasons why family caregivers do not have the conditions to assume the role of caregivers, one of the reasons was related to the issue of *choice*, that is, how the family and its members become caregivers due to the circumstances, without it corresponding to an actual choice. Either when the transition to dependency happens abruptly, in situations of sudden illness, or when it happens gradually, as is the case of aging-related dependency, the nurses reported that family members become caregivers without this being a choice of their own:

> I think they bring him home because . . . it's still a little bit our society: Oh, the family has to take care of him and I prefer to take him home and he stays at home but then they're not prepared . . . and they think that we're going to replace them. . . and the model in place is not one of wholly or partially compensatory care. (Nurse M)

The choice is often passive and made based on the often realistic belief that there is no one else to provide care and that there are no acceptable alternatives. The nurses believe that family members are not truly available to take responsibility for the role. They reported some situations in which people are left alone for long periods of time without any care being provided (food, hydration, mobilization, etc.). This is all the more worrisome considering that 77.7% of these people cannot turn around, sit down, or transfer themselves.

> And this when there's a caregiver, because, sometimes, here in the region of the UCC of Q, the population is very old, and we get to the patient's home and he's alone, he spends the day alone, his relatives go to work, his children are even out of town. (Nurse J)

Older people caring for older people

Another main reason reported by the nurses to explain the high proportion of unfinished care is the caregivers' age. Older people caring for older people, without physical and/or cognitive ability to act as partners in care, with few conditions, few resources, vulnerable, and often needing help themselves.

> Another difficulty is that the caregiver is often as old or older than the person being cared for ... in their 80s, 90s ... they have no physical capacity, often no cognitive capacity ... to collaborate with us as partners in care ... no matter how hard they try, they just can't. (Nurse A)

"then, as my colleagues have also talked about, it has to do with the caregivers' characteristics. They are older people taking care of older people, in poor conditions, lacking resources" (Nurse H).

The organizational model in force does not meet the needs

The nurses mentioned the existence of a conflict of expectations between the philosophy of the home care being provided and what the families want and need. They reported that the family/person expects a wholly compensatory care system, in some cases, partially compensatory, and the current organizational model only allows for care as part of a system of support and education:

> For example, in the beginning, I always ask them what they expect from me, what are the expectations - and what I feel, and this is my perception, for whatever it's worth, is that people want a partially or wholly compensatory model, that is, in practice, they are expecting us to replace them. And this is what it is, and we can't, it's impossible to go there every day to provide simple care. (Nurse D)

On the other hand, the nurses reported that access to home care is delayed, often missing the optimal window of opportunity for recovery. This has a lot to do with problems in referral, which is described as complex and time-consuming, leaving people without care for a long time:

> The problems have already been briefly described and they start with the patient's referral process. It's complex. I think that it doesn't matter how often the family health teams are explained how to refer the patient; it's complex. (Nurse G)

In addition, they expressed their concern that the delivery of home care is a temporary response that does not ensure follow-up during the processes of dependency, which are long and require continuous monitoring. The pressure to discharge patients after some time due to the established outcome indicators translates into a loss of the achieved health gains. According to the nurses, there should be several levels of response: from a level that ensures all aspects of care that the patient needs, through an intermediate level in which care is complementary to that provided by the caregiver, to a level of caregiver support/education and monitoring and follow-up of the dependent person. This would mean that they would not have to discharge them knowing that they still needed care

that the family cannot provide, pressured by unsuitable outcome indicators:

> We visit patients who need the ECCI in an initial phase, but then they need many maintenance treatments and what happens is that after 90 or 120 days our patients end up being discharged. And then, the next day, they're already asking for a new referral, and when we come back we feel that a lot of things have already been lost... I think that levels of response along the trajectory of care needs would make perfect sense. (Nurse G)

Another aspect often mentioned as leading to unfinished care was the work schedule. They reported that work and care are organized based on the time available and not on people's needs. Although the work schedule varies, it is usually from 9 am to 5 pm or, whenever possible, from 8 am to 8 pm, and, in exceptional and justified situations, on Saturdays. In their words, these schedules, for which they see no alternative due to current nurse staffing, hinder the continuity of care, making it difficult for people to access the care they need and leaving them completely alone in the afternoon, at night, and on weekends.

Unfinished care - a process that causes discomfort among nurses

The awareness of unfinished care and the need to set priorities causes feelings of helplessness and anguish among nurses. Nurses experience the process that leads to unfinished care as a dilemma. On the one hand, they believe that they could transform the home care provided into a good model of care if they had the necessary conditions:

> If we solved some problems . . . But if we had a team here, safe staffing, a multidisciplinary team, materials, transportation . . . which is what's regulated - so we're not asking for anything new... we need to have the tools to actually be able to work. I think so, I think that we would be able to fulfill the mission of the home-based long-term care network. (Nurse H)

On the other hand, the reality gives them again a feeling of helplessness, uselessness, frustration, and sadness, as can be seen in the following excerpts:

> It's dramatic [the care left undone] - but I don't know how to respond to this because it should be the Ministry or the Government, without a doubt, to provide these responses. On the field, the teams who are on the field can't do much more. (Nurse C)

"Then it's a demotivating factor for the team, in our current SWAT analysis, one of the threats was precisely the team's lack of motivation and frustration." (Nurse H). Their moral anguish and dissatisfaction with the situation and the feeling that this is not a local problem but rather a problem of the whole system are evident in the following excerpt:

> Primary health care is the poor relation of the National Health Service and the UCC and ECCI, which integrate it, are the extremely poor relation of the Health Care Centers. And I say this with some sadness because people need it more and more. (Nurse H)

Discussion

As mentioned above, the lack of time to deliver the required care is the main reason, around which the other factors gravitate, reported by the nurses for setting care priorities and leaving care undone. The phenomenon of adjusting people's care plans to resources/time (Tønnessen et al., 2011), which was described by the nurses, does not occur in a vacuum. Rather, it results from the conditions of possibility that are influenced, as they said, not only by a multitude of political-organizational factors related to the care organization model as a whole and the operational and care management but also by factors related to the complex nature of caring for the person and their family caregivers. The nature of the factors is consistent with that found by Sworn and Booth (2020) in a recent systematic review on the impact of missed care in community settings. The nurses reported the problems they encountered, and it is implicit in their interviews that the different aspects of structure, process, and outcome influence each other.

Several authors have found that massive time constraints influence nurses' practices in home care settings (Martinsen et al., 2018). The extensive workload and staff shortages lead to the decision to focus more on some aspects of care than others, which are left behind (Tønnessen et al., 2011; Turjamaa et al., 2014). The nurses in this study also reported that they feel forced to make complex decisions that depend on each situation encountered in the care relationship, where each person/family is unique and has their own individual and contextual needs. Nurses persistently strive to allocate their time and effort fairly among patients and thoroughly assess their needs (Martinsen et al., 2018). There is growing consensus that nurse staffing is a requirement to ensure patient safety and quality care (Ball et al., 2017; Phelan et al., 2018a). The data seem to point to problems in this area and the need to move on from calculating staffing based on historical data. Nurse staffing should be calculated differently taking into account the new demographic and health reality, the populations' needs, including patients' high level of dependency, the complexity of care, the caregivers' needs (both in terms of training for taking on the role and rest), the different travel times to each home (in an often extensive geographical area), and the need to work with other parties involved in the care process. These aspects are important for nurses in home care settings not to focus on the completion of the tasks controlled by the *clock* and adjust care to the time available, but rather implement a project that is co-constructed with the dependent person and their families to meet their needs and recover their maximum potential for autonomy (Turjamaa et al., 2014).

Moreover, the lack of resources mentioned by the nurses has been found in other studies. For example, the lack of means of transportation and travel time and planning should be considered in a home care model due to their potential impact on care outcomes as they are described as one of the reasons for missed care due to lack of time and one of the aspects hindering care delivery in this area (Neal, 1998; Phelan et al., 2018b).

At home, the nurse usually provides care alone, having to manage a set of unpredictable aspects during their autonomous professional practice and assume the responsibility for the decisions and actions taken. In this context, not having the necessary resources increases uncertainty and makes nurses and outcomes more vulnerable. The incorporation of technical aids and assistive devices and promotion of their use to recover the autonomy of dependent people is inherent to a conception of nursing care based on the best available knowledge and, as Meleis (2012) warns, the recognition of the importance of care can also be identified in the available and used resources. Not providing the recommended devices to people who depend on others for care is considered an omission of care (Phelan et al., 2018a).

The difficult collaboration between the health and social sectors in the provision of home care, which was found in this study, is also internationally described as one of the problems of care delivery in this area (Cylus et al., 2019). In line with the suggestion of the nurses in this study, a way to solve these problems would be the use of case managers, who are responsible for co-building the care project with the person/family and the other participants in the care process (Cylus et al., 2019).

One of the most frequent aspects in the nurses' interviews to explain the existence of unfinished care was the fact that the family, particularly the family caregivers, does not often have the conditions to exercise the role. This situation creates care needs that nurses cannot meet because the home care model is based on a logic in which the family performs most of the activities of daily living for the dependent person. Similarly, Beach and colleagues (2020) report that, although nurses recognize the critical role played by family caregivers in caring for and maintaining the health and well-being of their dependent relatives, they believe that the family is not able to take on the role of caregiver for several reasons.

Therefore, it is important to design a future model of care that ensures relevant professional help so that those who are dependent on others for self-care activities receive the care they need. The important thing is that the future model of care for people who are dependent on others for care creates the conditions for all people to receive the care they need, regardless of whether or not they have a family caregiver and whether or not the family caregiver is available to provide care. The future home care model should ensure that the caregivers who decide to assume this role are adequately prepared and receive relevant help and address the issue of older people caring for older people because, although the willingness to care is essential, the caregiver's ability to exercise this role should be assessed (Petronilho, 2013). It should be borne in mind that, in the processes of dependency, many family members are forced to become proficient in the provision of care that requires nursing skills and to do so within a relatively short period of time, that is, after admission to home care, which in many cases is not expected to happen (Neal, 1998).

Conclusion

The nurses who participated in this study know well and do not hide the reality of unfinished care, which is a reality that distresses them. Nurse conceptualize unfinished care as a phenomenon that begins with a problem - lack of resources/time - followed by a process in which nurses have to make a clinical decision to prioritize care, resulting in care left undone/unfinished care.

The lack of time to perform the necessary care is thus the main factor for nurses having to prioritize care and leave care undone. It is associated with several factors such as inadequate nurse staffing and fragmented work organization; the lack of resources and the complexity of care required by the health conditions of the dependent people, associated with the family caregiver's lack of ability to exercise the role of caregiver (because of the lack of a family caregiver, a caregiver who is too old, or a caregiver who became one not out of a real choice). These aspects translate into demands in the amount and diversity of care needed by the dependent person, for which the existing home care organization model is not prepared to respond in terms of the allocation of human and material resources and the type of organization and operation.

Ensuring the conditions for dependent persons to receive every aspect of care that they need is an ethical question that sooner or later all of us - political decision-makers, professionals, and citizens - will be called upon to answer. Thus, it is necessary to design a home care model that meets the actual needs of the individuals, regardless of whether or not they have a family caregiver.

Author contributions

Conceptualization: Bento, M. C., Silva, A. P.
Data treatment: Bento, M. C., Silva, A. P.
Formal analysis: Bento, M. C., Silva, A. P.
Methodology: Bento, M. C., & Silva, A. P.
Writing - original draft: Bento, M. C., Silva, A. P.
Writing - review and editing: Bento, M. C., Silva, A. P.

References

Beach, S. R., Schulz, R., Friedman, E. M., Rodakowski, J., Martsolf, R. G., & James, A. E. (2020). Adverse consequences of unmet needs for care in high-need/high-cost older adults. *Journals of Gerontology: Series B, 75*(2), 459–470. https://doi.org/10.1093/geronb/gby021

Bogdan, R., & Biklen, S. (1994). *Investigação qualitativa em educação: Uma introdução à teoria e aos métodos*. Porto Editora.

Cylus, J., Normand, C., & Figueras, J. (2019). *Will population ageing spell the end of the welfare state: A review of evidence and policy options*. WHO Regional Office for Europe.

Decreto-lei nº 101/2006 do Ministério da Saúde. (2006). Diário da República: I série n.º 109. https://dre.pt/dre/detalhe/decreto-lei/101-2006-353934

Galego, C., & Gomes, A. (2005). Emancipação, ruptura e inovação: o "focus group" como instrumento de investigação. *Revista Lusófona de Educação*, *5*(5), 173–184. https://revistas.ulusofona.pt/index.php/rleducacao/issue/view/62

Jones, T. L., Hamilton, P., & Murry, N. (2015). Unfinished nursing care, missed care, and implicitly rationed care: State of the science review. *International Journal of Nursing Studies*, *52*(6), 1121–1137. https://doi.org/10.1016/j.ijnurstu.2015.02.012

Kalisch, B. J., Landstrom, G. L., & Hinshaw, A. S. (2009). Missed nursing care: A concept analysis. *Journal of Advanced Nursing*, *65*(7), 1509–1517. https://doi.org/10.1111/j.1365-2648.2009.05027.x

Martinsen, B., Mortensen, A. S., & Norlyk, A. (2018). Nordic homecare nursing from the perspective of homecare nurses: A meta-ethnography. *British Journal of Community Nursing*, *23*(12), 597–604. https://doi.org/10.12968/bjcn.2018.23.12.597

Meleis, A. (2012). *Theoretical nursing: Development and progress* (5th ed.). Lippincott Williams & WilKins.

Neal, L. J. (1998). *Toward a theory of home health care nursing practice* (Doctor dissertation, George Mason University). Sigma Nursing Repository. https://sigma.nursingrepository.org/bitstream/handle/10755/17257/LNealBoylan_1.pdf?sequence=1

Petronilho, F. (2013). *A alta hospitalar do doente dependênte no autocuidado: Decisões, destinos, padrões de assistência e de utilização dos recurso- Estudo exploratório sobre o impacte nas transições do dependente e do familiar cuidador.* (Doctoral thesis, University of Lisbon). Repositório da Universidade de Lisboa. http://hdl.handle.net/10451/10572

Phelan, A., McCarthy, S., & Adams, E. (2018a). Examining missed care in community nursing: A cross section survey design. *Journal of Advanced Nursing*, *74*(3), 626–636. https://doi.org/10.1111/jan.13466

Phelan, A., McCarthy, S., & Adams, E. (2018b). Examining the context of community nursing in Ireland and the impact of missed care. *British Journal of Community Nursing*, *23*(1), 34–40. https://doi.org/10.12968/bjcn.2018.23.1.34

Schubert, M., Glass, T. R., Clarke, S. P., Aiken, L. H., Schaffert-Witvliet, B., Sloane, D. M., & De Geest, S. (2008). Rationing of nursing care and its relationship to patient outcomes: The Swiss extension of the international hospital outcomes study. *International Journal for Quality in Health Care*, *20*(4), 227-237. https://doi.org/10.1093/intqhc/mzn017

Silva, I., Veloso, A., & Keating, J. (2014). Focus group: Considerações teóricas e metodológicas. *Revista Lusófona de Educação, 26*(26), 175-190. https://revistas.ulusofona.pt/index.php/rleducacao/article/view/4703

Sochalski, J. (2004). Is more better?: The relationship between nurse staffing and the quality of nursing care in hospitals. *Medical Care, 42*(2), 67-73. https://doi.org/10.1097/01.mlr.0000109127.76128.aa

Strauss, A., & Corbin, J. (2008). *Pesquisa qualitativa: Técnicas e procedimentos para o desenvolvimento de teoria fundamentada* (2.ª ed.). Artmed.

Sworn, K., & Booth, A. (2020). A systematic review of the impact of 'missed care' in primary, community and nursing home settings. *Journal of Nursing Management*, *28*(8), 1805–1829. https://doi.org/10.1111/jonm.12969

Tønnessen, S., Nortvedt, P., & Førde, R. (2011). Rationing home-based nursing care: Professional ethical implications. *Nursing Ethics*, *18*(3), 386–396. https://doi.org/10.1177/0969733011398099

Turjamaa, R., Hartikainen, S., Kangasniemi, M., & Pietilä, A. M. (2014). Living longer at home: A qualitative study of older clients' and practical nurses' perceptions of home care. *Journal of Clinical Nursing*, *23*(21–22), 3206–3217. https://doi.org/10.1111/jocn.12569