Patient Safety Tip of the Week

November 26, 2013

Missed Care: New Opportunities?

This month there was an online first study (Ausserhofer 2013) and editorial (Wakefield 2013) in BMJ Quality and Patient Safety on a topic rarely discussed in the literature: missed nursing care. This is defined as any aspect of required care that is omitted either in part or in whole or delayed. We all, of course, have seen many consequences of such missed care when we do root cause analyses (RCA's) of adverse events – the patient who fell on the way to the bathrrom after his hourly rounding/toileting session was missed, the patient who developed a decubitus after 4 hours elapsed between turnings, the patient who attempted suicide when her q15minute check was delayed for 30 minutes, the patient in whom recognition of clinical deterioration was delayed because vital sign checking was delayed, and many others. And how often have you watched someone take away an untouched lunch or dinner tray from a patient?

But the concept of missed care as a potential contributor to adverse patient events as an entity needing further research can be attributed to Beatrice Kalisch, RN, PhD. In 2006 (Kalisch 2006) she first brought examples of commonly missed nursing care that have been associated with adverse patient outcomes. (Make no mistake: the root causes of missed nursing care extend well beyond nursing and those factors put nurses in the position of having to prioritize care, leaving some care undone or delayed). Prior to 2006 there was virtually nothing in the literature about missed nursing care and its occurrence was described as "undiscussable" (Kalisch 2009a).

Kalisch did qualitative studies of hospital nursing staff using focus group interviews and developed a tool, the MISSCARE survey, to measure missed nursing care (Kalisch 2006, Kalisch 2009a). We are not talking here about occasionally missed or delayed nursing care but rather regularly missed nursing care. Kalisch and colleagues found nine elements of regularly missed nursing care that have the potential to impact patient outcomes:

- Ambulation
- Turning
- Delayed or missed feedings
- Patient teaching
- Discharge planning
- Emotional support
- Patient hygiene

- I&O documentation
- Surveillance

They went on to identify 7 themes as to the reasons for missed care:

- Too few staff
- Time required for a nursing intervention
- Poor use of existing staff resources
- "It's not my job" syndrome
- Ineffective delegation
- Habit
- Denial

Given the incredible demands we place on our nursing staffs it is not surprising that some care goes undone or delayed. Under such circumstances nurses obviously prioritize which aspects of care to perform and which to delay or omit entirely. Understanding the thought processes involved in such prioritization is important.

Ambulation is one aspect of care often omitted. Early ambulation is important in reducing length of stay, fostering discharge to home rather than institutions, reducing the risk of delirium and other complications. Yet ambulation is often perceived as time-consuming. In some of Kalisch's original focus groups nurses often thought that nursing assistants were doing patient ambulation but nursing assistants noted they seldom ambulated patients. Interestingly, on some units ambulation was done more frequently because the physicians asked whether their patients were being ambulated.

Turning is another aspect of nursing care that is often delayed. We suspect that since Kalisch's original work in 2006 this may have improved since a variety of regulatory and pay for performance standards have increased hospitals' focus on preventing decubiti. Now when you walk into the room of a patient identified as being at risk for decubiti you typically see a clock on a white board that shows when the patient was last turned. But when circumstances get hectic there may still be delays in turning patients.

Delayed or missed feedings are common as we noted in the first paragraph. Many patients ultimately are undernourished during their hospital stay, with potential adverse consequences.

Note that there are solutions other than using nurses for some of the "nursing care" issues. We have often recommended having **dedicated "teams"** of appropriately trained individuals for regular turning of patients at risk for decubiti, or for ambulating patients, or for feeding patients. Such may be more practical at larger hospitals and may not be feasible at small hospitals.

Patient education, **discharge planning**, and providing **emotional support** are commonly inadequately carried out. All are obviously important in transitioning patients

to the next level of care and helping avoid rehospitalization. Yet all are perceived as time-consuming activities that tend to be prioritized to lower levels.

Patient **hygiene** includes bathing, mouth care, changing bed linens, etc. Again, these are often perceived as time-consuming activities that may be prioritized to lower levels.

Documentation of I&O's (intake and output) may be inadequate for several reasons. Sometimes the food trays are removed before a nurse could document what was taken in by the patient. Or a patient may have gone to the bathroom without staff help and voided an unmeasured amount of urine. Also keep in mind that we physicians are often ignorant of the time required for such documentation and often order "I&O" indiscriminately. There are many patients in whom I&O's are not needed at all and others in whom they are important only for a few days.

The last category, "**surveillance**", is a little harder to define. But clearly a nurse's "gestalt" of a patient is important in identifying patients who are deteriorating or otherwise at risk for potentially preventable complications. We noted in our March 2012 What's New in the Patient Safety World column "Value of an Expanded Early Warning System Score" that some MEWS have added scoring for the nurse's subjective impression of a patient's status, an addition we strongly support. But in Kalisch's original focus groups some nurses noted there were some patient rooms, often those most remote from the nursing station, that were entered much less often than others.

Probably more important than the categories of missed care are the **reasons for missed care**. As you'd expect having "**too few staff**" was the first response given in most of Kalisch's focus groups. There, of course, are many studies that have linked adverse patient outcomes and preventable complications to inadequate nursing staffing. And it is not just the staff-to-patient ratio that is important. You need to take into account patient acuity and unexpected heavy work demands.

But even when nurse:patient ratios are "acceptable" there may be additional factors that prevent nurses from carrying out all regular aspects of nursing care. In our December 15, 2009 Patient Safety Tip of the Week "The Weekend Effect" we noted work done by researcher Pattti Hamilton (RWJF 2009) highlighting the many additional activities nurses get stuck doing on weekends because of inadequate non-nursing staffing. Sometimes the nurses end up doing tasks such as transporting patients or even mopping floors. There is also less dietary and nutrition support, pharmacy and imaging services, physical therapy, patient teaching, and social services. She also points out that they may spend more time on the phone trying to track down doctors on weekends. So nurses end up doing many more tasks that they do not normally perform during regular "day" hours and they do not have as much time to do patient care and bedside nursing.

A somewhat related reason for missed care is **poor use of existing staff resources**. For example, there may be too few nursing assistants or aides. But this also includes supplies and equipment, medications, and other non-human resources. Kalisch has pointed out that experience levels of staff may vary from shift to shift and that issues with orientation and

handoffs are also contributing factors. In a subsequent concept paper (Kalisch 2009b) Kalisch and colleagues developed a Missed Nursing Care Model which highlights teamwork and communication issues as one of three major antecedents to missed care.

One critical factor is the **time required for a nursing intervention**. As we noted above, the perceived time-consuming nature of some aspects of care (ambulation, bathing, feeding, teaching, discharge planning, emotional support) often leads to lower prioritization. In some of Kalisch's work nurses noted they were often reluctant to start some of these activities because they felt they might get called away for other needs.

But the next group of reasons for missed care are common reasons for suboptimal outcomes in any organization or industry. One is the "**It's not my job syndrome**". For example, nurses often felt a task was no longer their responsibility once it was delegated to a nursing assistant. Often they would defer a task to the assistant even when they could have done the task much more efficiently themselves. Similarly, the assistants or aides sometimes felt that a task was the nurses' responsibility rather than theirs.

Ineffective delegation had several subthemes. One was failure of the nurse to obtain "buy-in" of the nursing assistant. A second subtheme was delegating without retaining accountability. And the third was lack of conflict management skills. Rather than dealing with these appropriately, many nurses end up doing the tasks themselves, taking away from other activities.

Some nursing staff get in the "**habit**" of not completing certain aspects of care. Once an aspect of care gets omitted once, particularly if there are no obvious untoward consequences, it tends to get omitted over and over. (Some of you will recall we have referred to this in other columns as "normalization of deviance"). In the subsequent concept paper (Kalisch 2009b) Kalisch and colleagues discuss the influence of the "norms of the team". An example given is that if nurses perceive that other nurses often do not ambulate patients, new nurses will tend to conform to that practice.

Lastly, **denial** about care not done was common, particularly for that care delegated to others.

Though they were not included as formal "reasons" in Kalisch's original paper (Kalisch 2006) there were several other important contributing factors noted. One was that nurses were more likely to complete aspects of care that physicians ordered or asked about frequently. Another was that those aspects where untoward consequences are delayed were more likely to go uncompleted. For example, some of the consequences of inadequate nutrition or ambulation or teaching are not seen until after discharge.

Another study using the MISSCARE survey (Shuckhart 2010) found 3 factors noted in the Kalisch concept paper (Kalisch 2009b) contributed to many of the reasons for missed care. These included labor resources (63.2%), material resources (36.7%), and communication (31.9%).

In a test of the concept Kalisch and colleagues (Kalisch 2012) applied the MISSCARE survey and a measure of nursing staffing (hours per patient day or HPPD) to look at relationship to patient falls in 11 acute care hospitals of varying size. As expected, hours per patient day was negatively associated with occurrence of patient falls and the higher the missed care score the higher the patient fall rates. The study suggested that missed nursing care was at least one of the mediators of the relationship between staffing levels and falls.

The more recent study that brought the formal concept of missed care to our attention (Ausserhofer 2013) found frequent evidence of undone nursing care in almost 500 hospitals in 12 European countries. Results did show that in hospitals with more favorable work environments and better nurse:patient staffing ratios and those with lower proportions of nurses carrying out non-nursing tasks, fewer aspects of care were left undone. The accompanying editorial (Wakefield 2013) raises a number of questions for future research regarding the concept. It also emphasizes a recently recognized concept "**complexity compression**" as a likely contributing factor to missed nursing care. By that the author means that nurses are often asked to assume additional and unplanned responsibilities while at the same time conducting their other responsibilities in a condensed time frame.

All the articles cited in today's column have certainly brought the concept of missed care to our attention. Using tools like the MISSCARE survey to identify what aspects of care are not being completed, trending them over time and, most importantly, identifying and ameliorating the root causes could result in significant improvement in patient outcomes.

We also suspect that we could apply similar concepts to care by physicians (eg. in office practices or clinics) or other healthcare workers in other settings and find many of the same factors leading to missed care in those settings.

Kalisch and colleagues have done a superb job in bringing into the open a problem that has long flown under the radar and identified a significant opportunity for improvement.

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