



Briefing paper: Missed care, care left undone, covert rationing of care and allocation of the nursing resource - through an ethics lens.

Scott PA, Suhonen R, Leino-Kilpi H, Schwanda M, Halvorsen K, Tønnessen S, Christiansen K, Harvey C, Habermann M, Hjaltadóttir I, Papastavrou E.

On behalf of the RANCARE Consortium COST – CA 15208¹

Summary

Concerns regarding missed nursing care or nursing care left undone has emerged in the nursing literature over the past 19 years. The first reported consideration of the matter appeared in a paper by Aiken et al. 2001. The topic has received more focused consideration in recent years, from a variety of perspectives. A state of the science review of work to date on missed care/care left undone was published by Jones et al. in 2015.

In light of the above evidence this paper sets out to summarise the level of ethical awareness explicit in the key findings regarding nursing care left undone/missed nursing care internationally. Attention is drawn to the absence of discussion of resource allocation and rationing in nursing from an ethics perspective. Some of the reasons why this is unacceptable and needs to change are also highlighted.

Recommendations:

- There is an identified need for more education, for both members of the nursing profession and the general public, on matters regarding resource allocation and rationing of nursing care; and the underlying ethical, as well as financial and patient safety, issues involved. The ethical concerns involved range from issues of access to nursing care through to discrimination and the undermining of patient rights to care, for individuals and/or groups of patients – for example those structurally excluded from care, asylum seekers, LGBT+ and the socially and economically deprived members of a population.
- The identified lack of consideration of the nursing resource from an ethics perspective needs to be addressed as a matter of urgency. Resource allocation is a relevant and important topic of discussion in health care. Nursing care is a key element of health care and access to health care. Neither overt nor covert rationing of nursing care should be happening without citizens (as members of the general public), the Ministry of Health, the government, nurse managers and nurses themselves (a) being aware of this fact and (b) feeding in effectively to the discussion and decision making on such resource allocation and rationing.

¹ Recommended Citation

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Introduction:

In October 2013 Ausserhofer et al. reported findings from an exploration of the reality/prevalence of missed nursing care across 11 European Countries. This paper² indicated that nursing staff across all 11 participating countries confirmed that there were examples of missed care/care left undone on a regular basis, on shifts which they worked. In addition Ausserhofer et al. identified that very similar elements of nursing care was left undone across the participating countries: “Across European hospitals, the most frequent nursing care activities left undone [on a nursing shift] included ‘Comfort/talk with patients’ (53%), ‘Developing or updating nursing care plans/care pathways’ (42%) and ‘Educating patients and families’ (41%).”

Figure 1

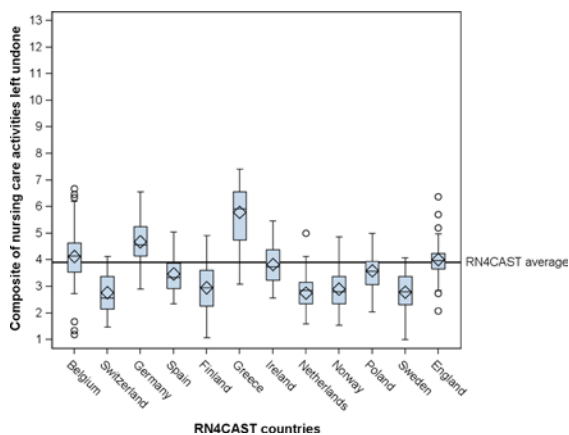


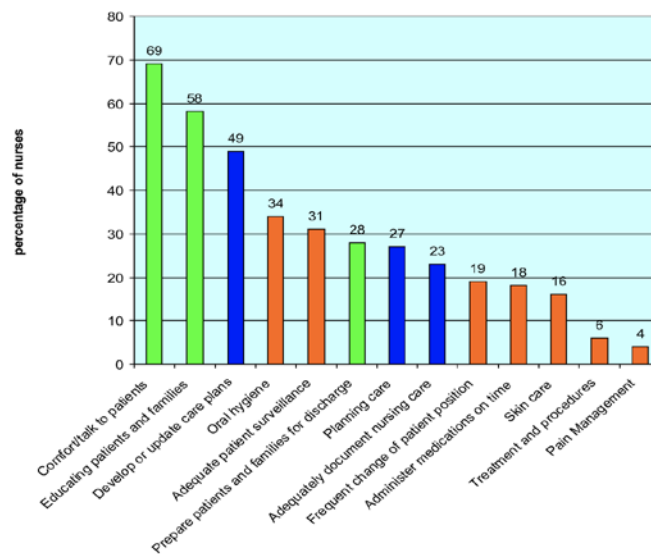
Figure 1: Between-country and within-country variability in the number of nursing care activities left undone—composite score in 488 European hospitals. The box-and-whisker plots should be interpreted as follows: The boxes means that 50% of the hospitals’ nursing care left undone composite scores within the country were in the IQR, that is, between the lower quartile (25th percentile) and the upper quartile (75th percentile). The line within the box represents the median, and the rhombus the mean. The whiskers represent the minimum respective the maximum nursing care left undone scores (without outliers). The circles represent outliers. (Ausserhofer et al 2013).

² Ausserhofer et al. (2013) is one of the published outputs from the RN4CAST EU funded programme of research on forecasting future nursing work force (FP7/2007-2013 grant agreement No. 223468)

In the context of the Irish arm of the RN4CAST study for example the following bar chart indicates the types of nursing care left undone during nursing shifts.

Figure 2

Care Left Undone: Irish Hospitals 2009 – 2010



(Kirwan M 2012)

These studies confirm or replicate findings that had begun to emerge from the work of Aiken et al. (2001), Kalisch (2006) in the USA and Schubert et al. (2008) in Switzerland – all indicating findings of missed care, care left undone/covert rationing of nursing care. A review of the state of our knowledge in this area was published by Jones et al. 2015. Kalisch’s work also indicted that some nursing staff members experienced significant distress as a result of leaving care unfinished. Aiken et al. (2001), Ball et al. (2013), and Scott et al. (2013) linked incidents of care left undone with nurse staffing levels and nurse reported quality of care. The

RANCARE COST Action 15208 was developed in order to explore this important but under-researched topic, to synthesise the information on missed care/care left undone/covert rationing of care across European countries, and to provide ethical reflection and analysis of the topic.

RANCARE COST Action

The work of the RANCARE COST Action (CA15208) team has developed and built on the earlier work and discussions in a number of ways, not limited to, but including the following:

1. Working towards greater conceptual understanding and consensus on what missed care/care left undone/unfinished care means across countries and health systems (Jones et al. 2019, Palese et al. 2019, Nova et al. 2019, Zeleníková et al. 2019).
2. Examinations of hospital safety climate (Gurková et al. 2019), the cost of nursing work (Harvey et al. 2018).
3. Seeking to ensure that nursing care and nursing time be treated as a significant and important health care resources. Resources that should be governed by explicit discussion, principles and guidance on prioritization, including an overt recognition that allocation of nursing care/nursing time is **an ethical issue**, in addition to being a matter of financial, professional and patient safety concern (Scott et al. 2018; Suhonen et al. 2018, Suhonen and Scott 2018, Evripidou et al. 2019, Scott, Suhonen and Kirwan 2020, Igoumenidis et al. 2020, Papastavrou et al. 2020, Tønnessen et al. 2020a, Tønnessen et al. 2020b).
4. Commencing discussions on a consideration of missed care from the perspective of patients – Gustafsson et al. 2020.

5. Direct focus on education, training and patient safety issues (Kirwan et al. 2019, Cordeiro et al. 2020).

The impact of the work of the RANCARE Cost Action will be most impactful if directors of services and service planners and policy makers are briefed and informed with regards the key elements of RANCARE outputs. The key concern in this briefing paper is raising awareness of the ethical aspects of missed care/care left undone/covert rationing of nursing care.

It is clear that nursing is an important and costly resource in health systems internationally. It is well recognized that nursing staff at the bedside play key roles in ensuring safe, humane patient care that supports quality of care provision, patient recovery, and enhanced experience of health care (Aiken et al. 2014, Lee et al. 2017, Shin et al. 2018). As suggested above a growing number of studies also indicate that due to pressure of work, and insufficient nursing staff to meet the demand at the bedside, some aspects of nursing care is being left undone or not finished (Ausserhofer et al. 2013, Ball et al. 2013). There is also growing evidence that incidents of care left undone or missed care is associated with poorer quality of care, patient safety issues and increased patient morbidity and 30 day mortality (Aiken et al. 2014, Ball et al. 2013, Griffiths et al. 2014, DoH 2018). For these kinds of reasons a number of states in the US and Australia have moved to mandate specific nurse-to-patient ratios (Seago 2002, Seago et al. 2003 Spetz 2001, State of Victoria 2019, Queensland Health 2019) and other countries have developed guidance on the appropriate staffing and skills-mix that should be available on wards and units in acute hospitals (NICE 2014, DoH 2018, Shin et al. 2018). There appears to have been a reluctance in European countries to move to mandate staffing levels or nurse-to-

patient ratios. However, to our knowledge, there is no clear, definitive account of this matter in terms of a European approach.

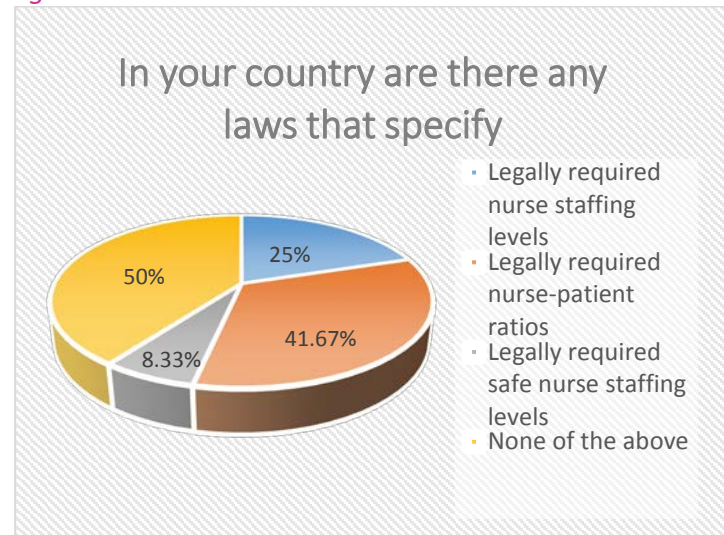
Issues regarding what the size the available nursing resource should be, how it should be allocated, and what kinds of care nurses should provide to the patients in their care, are matters of ethical as well as financial and professional concern. To gain some insight into whether and how the ethical dimension of identifying and allocating the nursing resource is attended to throughout Europe we decided to work with members of the RANCARE consortium, as the consortium has representation from across Europe – east, west, north, south and central.

Participants from 12 RANCARE countries completed a short questionnaire seeking clarification on the presence or absence of either legally mandated nurse staffing levels or nurse patient ratios, and/or national guidelines on safe staffing levels or nurse patient ratios. The questionnaire also sought clarification on whether such legislation or guidelines were generalized across care areas, or only applied to specific care areas – such as acute medical and surgical units, intensive care units, care of the elderly units, community nursing and so forth. Participants were also asked to comment on what they perceived as the key drivers of such legislation or national guidance where legislation or national guidelines on nursing staffing existed – e.g. quality of care issues, patient safety, access to care, human right to health care and so forth.

Findings: The finding from this short questionnaire involving 12 European countries (Austria, Croatia, Cyprus, Denmark, England, Finland, Iceland, Ireland, Italy, Norway, Spain and Turkey) are as follows:

Figure 3 Legal requirements regarding nurse staffing levels and /or nurse patient ratios

Figure 3



In five out of the 12 responding countries (Austria, Croatia, Cyprus, Finland, Turkey) there are explicitly mandated nurse-patient ratios, nurse-bed ratios, staffing levels for the hospital system nationally. Austria has nurse-bed ratios in the hospital system, nurse-patient ratios in nursing homes and a minimum of one doctor and one RN for primary care centers. In Finland there is legislation on specific staffing ratio requirements in older peoples care settings.

The case of Finland: Legislation was established in 2012 to regulate the numbers and qualifications of nurses in older peoples' care settings (Act on Supporting the Functional Capacity of the Older Population and on Social and Health Care Services for Older Persons 980/2012) Section 6: In order to be able to evaluate the quality and adequacy of services, local authorities must on a regular basis gather feedback from service users, their family members and other persons close to them, and from municipal staff. Furthermore, local authorities must collect information

on the financial resources used for services and the number and educational qualifications of the staff. The observations presented by the municipal social services ombudsman in his or her annual report must also be taken into consideration in the evaluation.

This legislation was put into action with the national guidelines on quality (Laatusuositus hyvän ikääntymisen turvaamiseksi ja palvelujen parantamiseksi 2017–2019, MSAH 2017.) The ratio of nurses to older people in long-term or residential care (24h care service) is 0.5. There is a new legislation initiative in the Finnish Parliament to raise the ratio to 0.7 nurse per 1 patient. It is planned that this will be enforced before 2023 (HE 4 2020 vp.).

In 6 responding countries (50% of sample) there are no legal requirements of this nature with regards nurse staffing levels or nurse-patient/nurse-bed ratios.

In two countries UK and Ireland there are national guidelines on safe staffing in acute medical and surgical units (NICE, UK):

<file:///C:/Users/0119275s.UDS/Download/s/safe-staffing-for-nursing-in-adult-inpatient-wards-in-acute-hospitals-safe-staffing-for-nursing-in-adult-inpatient-wards-in-acute-hospitals-overview.pdf>; <https://improvement.nhs.uk/resources/?keywords=Safe%2C+sustainable+staffing&ordering=last-updated-desc&p=1> and the Framework for Safe Nursing Staffing and Skills –mix in General and specialist medical and surgical setting in Ireland: <https://www.gov.ie/en/publication/2d1198-framework-for-safe-nurse-staffing-and-skill-mix-in-general-and-speci/?referrer=/wp-content/uploads/2018/04/nursing-taskforce-report.pdf/>. In Norway there is national guidelines for nurse-patient ratios in both acute care and intensive care, also regulated according to the level

of intensive care

(https://www.nsf.no/Content/2265711/R-etningslinjer_for_IntensivvirksomhetNORGE_23.10.2014.pdf). In Iceland there are guidelines from the Directorate of Health for safe staffing and skill mix for nursing homes

<https://www.landlaeknir.is/servlet/file/store93/item25523/Vi%C3%B0mi%C3%B0%20um%20m%C3%B6nnun%20%C3%A1%20hj%C3%BArunarheimilum%20%20%C3%BAtg%C3%A1fa%20september%202015.pdf>

In other countries such as Italy safe staffing ratios / levels are being determined and/or examined at regional/local rather than national levels.

Where such legislation and /or guidance, on nurse staffing levels, or recommended staff-patient ratios exists, the general consensus is that patient safety, assessed care needs and quality of care are the key driving factors – rather than any explicit recognition of the ethical issues related to resource allocation and rationing of nursing care. However in Cyprus, Finland and Turkey explicit concerns with patients' rights to health and nursing care or unlawful discrimination and undermining of patient rights to health and nursing care is also evident.

Understanding of the ethics dimension and the ethical issues is important – from the perspectives of the nursing profession, individual nurses, patients and members of the general public. If this is not clearly understood a number of significant ethical problems may arise:

- (a) The idea of nursing care as a limited resource is not visible and not understood.
- (b) The nursing resource is perceived as unlimited, with nurses consequently having unlimited capability to absorb ever increasing (often unmonitored) demand of care and attention.
- (c) Health service managers are absolved from considering the implications of the

resource allocation decisions they are making regarding the nursing resource available.

(d) Individual nurses at the bedside then find themselves in a position where they covertly allocate and ration their care, due to lack of time, overwhelming demand, poor decision making, organizational skills deficits and so forth.

(e) Patients are left exposed to the direct consequences of limited or no nursing care.

(f) There is no scrutiny or peer review of the allocation/rationing decision of individual nurses - which leads to risks of discriminating against particular patients or groups of patients.

(g) Nurses individually carry the moral burden of these moral decisions.

(h) This is an abdication of organization responsibility and duty of care to both staff and patients (Scott et al 2018).

The findings above:

- Highlight a need for more education, of both nurses and members of the public, on matters regarding resource allocation and rationing of nursing care, and the underlying ethical as well as financial and patient safety issues involved. The ethical issues involved range from issues of access to nursing care through to discrimination and the undermining of patient rights to care, for individuals and/or groups of patients – for example asylum seekers, LGBT+ and the socially and economically deprived members of a population.
- Indicate a lack of clear consideration of the nursing resource from an ethics perspective. Resource allocation is a relevant and important topic of discussion in health care, as is how best to use the often limited resources available. Nursing care is a key element

of health care and access to health care. Neither overt nor covert rationing of nursing care should be happening without citizens (as members of the general public), the Ministry of Health, the government, nurse managers and nurses themselves (a) being aware of this fact and (b) feeding in effectively to the discussion and decision making on such resource allocation and rationing.

By ignoring the ethical issues involved in decisions regarding the allocation of the nursing resource (including a consideration of the education level of the nursing workforce to be allocated), we are continuing to undermine the visibility of crucial aspects of nursing care (care planning, comfort care, discharge planning for example) and thus making little attempt to explicate or cost this care. This undermines the experience of both patients and nurses, deeming invisible, and thus unimportant, the 'softer'/humane aspects of nursing care, such as comfort care, help in meeting hygiene needs, patient and carer education, psychosocial support and emotional care, protection of a patient's dignity, support for the exercise of patient autonomy. Such elements, though largely invisible, are core to humane, high quality care. These less visible aspects of care are in fact the aspects of nursing care often most valued by patients (Wysong and Driver 2009). They are also the elements of the job that may act as intrinsic motivators for nurses (Aiken et al. 2002, Hayes et al. 2010) – leading to job satisfaction / retention and humanising of the health system – thus not only ensuring better patient care and experience, but also helping retain nurses in the health system.

Ignoring the ethical elements of missed nursing care/care left undone, leads to a

lack of recognition and reflection on both the drivers and the key ethical consequences of decision-making on the allocation of the nursing resource at all levels (nationally, locally, at both the institutional level and the level of direct patient care at the bedside).

Ignoring the ethical elements of missed nursing care/care left undone is also likely to perpetuate covert rationing of nursing care, direct and indirect discrimination and infringement of human rights; in addition to an unrecognized, increased moral burden on individual nurses delivering direct care. Covert rationing of nursing care occurs in a context where such rationing decisions are implicit, often unanalyzed, 'on the spot', in response to real or perceived overwhelming demand, and where the rationing of the nurse's time and care is not open to peer scrutiny, review or accountability (Scott et al. 2018).

However as Scott et al. 2018 highlight,

“The focus on individual bedside rationing in the rationing discussion in nursing also contributes to obscuring the nature of the ethical problem of rationing in nursing, insofar as it does not appear to conceive a reduced allocation of nursing staff as itself being rationing of a crucial resource. An ethical justification for rationing the resource of nursing staff, in light of its likely consequences, needs to be provided, rather than effectively rationing the staff resource, but passing on the responsibility for specific rationing decisions in care to individual nurses. Both problems of rationing, the institutional and the individual, need to be recognised as such, and ethical reflection needs to be applied to both.”

Conclusion:

The ethical aspects of educating, allocating and rationing the nursing resource should be a key concern for health policy makers, health service managers, nurse leaders, individual nurses, patients and members of the public. As should the current largely covert practice of prioritization of care requirements and rationing of nursing care at the bedside. It is within all our interests to be aware of these matters and give them due consideration. This is in order to ensure transparent, informed decision making with regards to the allocation of the nursing resource – at national, regional, local levels and at the bedside - that is open to scrutiny and peer review. Such decision making should include informed professional nursing input. Such decision making is a shared responsibility inclusive of policy makers, health services managers, nurse leaders and clinical nursing staff – it is not a burden that should covertly and implicitly be left to the individual practitioner at the bedside, with all the attendant risks such covert decision making can carry.

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