MILECKA, Dorota, HOMĘTOWSKA, Henryka & MANULIK, Stanisław. The rationing of nursing care phenomenon in the light of scientific reports – definitions, system solutions, assessment methods – PART I. Journal of Education, Health and Sport. 2023;13(4):281-291. eISSN 2391-8306. DOI http://dx.doi.org/10.12775/JEHS.2023.13.04.033
https://apcz.umk.pl/JEHS/article/view/42429
https://zenodo.org/record/7688373

The journal has had 40 points in Ministry of Education and Science of Poland parametric evaluation. Annex to the announcement of the Minister of Education and Science of December 21, 2021. No. 32343.
Has a Journal's Unique Identifier: 201159. Scientific disciplines assigned: Physical Culture Sciences (Field of Medical sciences and health sciences); Health Sciences (Field of Medical Sciences and Health Sciences).
Punkty Ministerialne z 2019 - aktualny rok 40 punktów. Załącznik do komunikatu Ministra Edukacji i Nauki z dnia 21 grudnia 2021 r. Lp. 32343. Posiada Unikatowy Identyfikator Czasopisma: 201159.
Przypisane dyscypliny naukowe: Nauki o kulturze fizycznej (Dziedzina nauk medycznych i nauk o zdrowiu); Nauki o zdrowiu (Dziedzina nauk medycznych i nauk o zdrowiu).
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The authors declare that there is no conflict of interests regarding the publication of this paper.
Received: 05.02.2023. Revised: 22.02.2023. Accepted: 01.03.2023.

The rationing of nursing care phenomenon in the light of scientific reports – definitions, system solutions, assessment methods – PART I

Zjawisko racjonowania opieki pielęgniarskiej w świetle doniesień naukowych – definicje, rozwiązania systemowe, metody oceny – CZĘŚĆ I

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Abstract
Rationing of nursing care is a widespread and growing phenomenon whose causes are multifaceted and whose consequences are serious. Nursing rationing is defined as withholding or failing to perform necessary nursing tasks due to insufficient time, staffing, and/or inadequate skills. Nursing rationing is also defined as omission, delay, or failure to complete, which qualifies as an error of omission. Unfinished nursing care has many negative consequences for patients, nurses, and organizations. The presented series of three papers aims to show many important aspects related to care rationing. This first part of the series of rationing of nursing care phenomenon will address definitions and concepts of rationing of nursing care, rationing of nursing care in the context of health care rationing, rationing of care versus omission of care or medical error, methods for assessing the rationing and the quality of nursing care, and main reasons for rationing of nursing care.

Keywords: rationing nursing care; definitions of rationing; concepts of rationing; system solutions; assessment methods; scientific reports.

Introduction

The concept of rationing of nursing care and its synonyms (loss, lack, shortage, delay, missed care, rationing, omission, error of missed care, missed care, hidden rationed care) had a genesis of several years. However, the term missed care was first used in 2006. Beatrice J. Kalisch [1], an American nurse and professor at the University of Michigan, was the first to present a qualitative study on the subject in her article Missed Nursing Care a Qualitative Study. The research method used in this study was face-to-face interviews with nurses captured in the form of recordings. The research questions were: what nursing care is regularly missed, and what reasons for missing are given by nurses? Among the nursing activities, nine were identified as regularly omitted: mobilizing, changing body position, delayed or missed feeding, patient education, discharge planning, emotional support, hygiene, documenting fluid and food intake and output, and supervision. As for the reasons for missed care in the survey discussed above, nurses cited: insufficient staffing; time required to perform given procedures – discouraging their performance; inappropriate use of existing staff resources – poor work organization; unwillingness to perform duties belonging to other patient care workers and collaborate – "that is not my job" (that is not my responsibility); ineffective delegation of tasks by nurses to nursing assistants, being a source of, among other things. Among other things, conflicts and delaying work; the habit of missing out on some aspects of care due to lack of time (since I did not do it once, I will do it again); denial as a way of avoiding questions from nursing assistants out of concern - was the care complete, was something omitted [1].

Challenges in rationing of nursing care – definitions and concepts

Prior to the above-mentioned study by Kalisch et al. [1], there was an even earlier report from 2001 on the problems of nursing shortages, and this is the first report to recognize the problem – care left undone. In it, Aiken et al. [2] present a report from 700 hospitals in 5 countries (USA, Canada, England, Scotland, and Germany), in which nurses report shortcomings in their work environment and the quality of hospital care, attributing the cause to organizational and management issues belonging to managers. Schubert et al. [3] define nursing rationing as the withholding or failure to perform necessary nursing tasks due to insufficient time, staffing levels and/or different skills. On the other hand, missed nursing care exists when any aspect of care is omitted or delayed, in part or whole, is 2009, and its author is Kalisch [1,4]. Other terms found in the English-language literature are: nursing tasks left undone (NTLU) [5]; unmet nursing care needs [6]; omitted care [7]; care left undone [2,6]; rationing of nursing care [8]; implicit rationing of nursing care [8,9]; unfinished nursing care, tasks undone [10]; task incompletion [11]; delayed care; covert rationing of nursing care. Because of the need to undertake further research in the field of nursing rationing internationally, the research project "RANCARE Rationing – Missed Nursing Care: an International and Multidimensional Problem" was launched, which, in addition to the main objective related to nursing shortages and the resulting gaps in patient care, efforts were also made to adopt a common definition of nursing rationing [12,13].

Rationing of nursing care in the context of health care rationing

In order to discuss the concept of rationing of nursing care, it is necessary to start by discussing the rationing of health services, as not all health services are universally available or available at one time to all patients. The reasons may lie, for example, in limited resources, as is the case with the availability of organs for transplantation, or in financial constraints, such as waiting in a waiting queue for a service that may be surgery. In the literature on this subject, one can also find the term implicit and explicit rationing [14]. This includes the above examples and is based on previously developed overt criteria. Another example of explicit rationing can be found in the Priorities for Regional Health Policy for the Lower Silesian Voivodeship for 2019-2021 adopted by the Provincial Health Needs Councils appointed by the Voivodes – Priorities for Regional Health Policy for the Lower Silesian Voivodeship for 2019-2021 covering, in order, 21 areas with Oncology in the 1st place (274 points) and Urology in the last 21st place (186 points). In addition, the document includes goals, expected implementation time, preferred ways to achieve the goals, evaluation measures, and justification. It is noteworthy that among the priorities appeared areas related to training of medical personnel (2nd place) and infrastructure and development of new technologies (14th place). Additional information is that the priority – training of medical personnel appeared for the first time; it was not in the priorities for 2017-2018. The rationale for the priority – training of medical personnel is the exponential increase in the vacancy of qualified medical staff, which results in a

decrease in the availability and quality of the health service. This phenomenon requires the creation of better conditions for acquiring qualifications in the professions of doctor, nurse, midwife, the medical caregiver [15,16].

On the other hand, an example of implicit rationing could be waiting for a procedure or diagnostic test during a hospital stay. In this case, the doctor or nurse makes decisions guided by their criteria and individual approach to patients. Both implicit and explicit rationing of health services is one of the fundamental problems of bioethics. The moral side of rationing health services was pointed out by Szewczyk, who stressed that rationing could only be spoken of about goods with three characteristics: generally recognized value, limited quantity (access), and, as B.J. Russell [17] states, controllability. Szewczyk [18] emphasizes that rationing applies only to finite resources, and resource scarcity even makes rationing in medicine a necessity. A shortage of resources results in an insufficient supply, which cannot be increased by additional funding. In practice, such a situation occurs, for example, in the case of organs for transplantation. Another situation is in the case of financially limited services, and the allocation of these goods should be subject to socially acceptable rules; hence, as Szewczyk [18] states, healthcare rationing requires the careful development of criteria (rules, principles) for allocation [18]. In 2001, American physician and bioethicist Peter Ubel [19] defined healthcare rationing, understanding it as overt or covert mechanisms that allow people to do without beneficial services.

The third feature: goods whose distribution is subject to control can be rationed. Can nursing rationing qualify as rationing of health care benefits? Do nursing benefits constitute goods that have three characteristics: generally recognized value, limited quantity, and controllability? The very first thought rejects such an approach since the patient admitted to the hospital has already passed the stage of rationing by being at least in the waiting queue; therefore, it should not be subject to separation or restriction of nursing care. Nursing care should be organized in such a way as to provide the patient with the level of nursing care required by the patient's condition. It should be emphasized that nursing care rationing is a negative phenomenon, harmful to patients and nursing staff, and without any regulation based on developed and socially accepted criteria/rules/rules of separation. The ethical dimension in nursing rationing is being studied. Rooddehghan et al. [20] addressed this problem with the assumption that rationing of various needed services, such as nursing care, is inevitable due to unlimited needs and limited resources. The above-mentioned author, while studying aspects of care rationing in Iran, found that the levels at which health practice is rationed and the knowledge of rationing are important structural factors in the development of an equal, appropriate, and ethical health care system and that the process of rationing care itself is crucial because it not only affects people's lives but also reflects the values prevalent in society. Through interviews with study participants, it was determined that the reasons for rationing nursing care are: patients' needs and demands, routine, and VIP patients, while the effects of rationing nursing care are: lack of care, patient dissatisfaction, and nurses' guilt. The ethical dimension of nursing rationing involves assessing potential conflicts between personal and professional values [20].

Rationing of care versus omission of care or medical error

According to Szewczyk [14], there is no universally accepted definition of medical error; hence in understanding the term in question, he proposes to clarify such concepts as iatrogenesis, adverse events, medical errors, and potential medical events (near misses). The concept of iatrogenesis indicates that it is related to the health care system and the conduct of employees acting as functionaries of this system; adverse events are related to medical care (all stages such as diagnosis and treatment) and the organization and equipment of the care delivery system rather than the disease itself; medical errors are understood as preventable adverse events (i.e., the harm that cannot be prevented is not the result of errors), and potential adverse events are understood as a timely noticed mistake, which makes it so that harm does not occur. However, it is important to monitor them because, through these actions, patient safety is improved.

In the nurse's profession, iatrogenic errors are predisposed by a small number of nurses, too many patients per nurse, insufficient quantity and quality of equipment and materials, poor work organization, insufficient knowledge, and ignorance of procedures [21]. As far as adverse events are concerned, according to Kutryba [22], chief specialist at the Center for Monitoring Quality in Health Care, "the largest volume of them relates to patient falls, deviations and failures of medical equipment, i.e., events that de facto do not directly charge the staff." Medical error in consideration of Przybylska et al. [23] is analyzed as a serious threat to the proper functioning of the health care system.

This is also the context in which an error of omission in nursing care should be considered, which can occur at all stages of nursing work, so that it can be a diagnostic error, a therapeutic error, a nursing error, a prognosis error, or an organizational error. In the case of the latter, the blame for its occurrence

must lie with anyone who contributed to the poor organization of work, so the circle of those responsible for its occurrence is expanded, and there may also be a situation in which there is no involvement and fault of the nurse in the occurrence of an organizational error. Among the causes of organizational errors in the work of a nurse, Marczewska et al. [24] mention, among others, improper selection of people to work on duty teams, the inadequate flow of information in treatment teams, illegible maintenance of medical records, nurses performing activities outside their competence - secretarial, room, administrative, inadequate equipment of workstations, poor labeling of medicines-similar packaging.

According to the Polish Law on the Profession of Nurse and Midwife Art.11.1, "A nurse and midwife perform their profession, with due diligence, in accordance with the principles of professional ethics, respecting the rights of the patient, caring for his safety, using the indications of current medical knowledge ..." [25]. Therefore, unlike medical error in nursing work, there may also be adverse consequences for patients resulting from a breach of the principle of diligence, that is, negligence, carelessness, or lack of soundness. For both errors, negligence, and lack of due diligence in the performance of their profession, nurses can be held liable for professional, civil, criminal, and labor liability [26]. In addition, it should be noted that nurses are held professionally liable before the bodies of the professional nursing and midwifery association (the ombudsman for professional responsibility and the court of nurses and midwives) for: culpable violation of the rules of professional practice, violation of the regulations governing the practice of the nursing profession, conduct contrary to the principles of professional ethics [27].

A survey by the Center for Public Opinion Research (*Centrum Badania Opinii Społeczenej*, CBOS) shows that 33% of Polish people have experienced medical errors. However, as the author of the communication, Omyla-Rudzka [28], stresses, the survey results should be treated as a particular approximation of the scale of medical errors since the survey instead shows the state of public awareness related to making mistakes.

One of the errors in nursing work is medication error. According to Zięzio [29], more than 42% of nurses surveyed have witnessed a medication error, while 25.7% of respondents admit to having made one themselves. In the opinion of nurses, the most common error is the administration of a previously discontinued drug. In contrast, according to the respondents, the main reason for errors made by nursing staff is being burdened with too many responsibilities.

In diagnosing medical errors or adverse events, the most important thing is prevention and, if they occur, taking corrective action as soon as possible. Among the ways to reduce the incidence of medical errors are all activities that improve the quality of medical services, such as monitoring of adverse events, introduction of standards of conduct, and patient satisfaction surveys. An example is the accreditation standard - the Center for Monitoring Quality in Health Care (*Centrum Monitorowania Jakości w Ochronie Zdrowia*, CMJOZ), according to which the hospital identifies and collects data on adverse events. The main goal of these activities is to improve patient safety, according to Reporting and Learning Systems (RLS) [30]. As highlighted by Przybylska et al. [23], other activities include the need to disseminate basic ergonomics knowledge among medical staff. A now-available monograph titled "Patient and Medical Staff Safety - Ergonomic Considerations" is intended for medical staff and managers responsible for managing medical entities as a guide to good practices to help understand the essence of patient and medical staff safety in daily work [31].

Rationing of nursing care is defined as an omission, a delay, an incompletion, but also as an error of omission. An expansion of this concept can be found in the article by Kalisch et al. [32] and in an earlier report by Kalisch et al. [33], in which the authors, using MISSCARE, showed that the reasons for missed care were labor resources (85%), material resources (56%) and communication (38%). Overlooked activities: assessment was overlooked by 44% of respondents, interventions and primary care were considered overlooked by 73% of nurses and planning by 71% of survey participants. The results of this study allow us to conclude that a large percentage of patients were at risk due to lack of care or error of omission. The most frequently cited reasons for lack of care among labor resources were: unexpected deterioration of the patient's condition, emergencies, low staffing levels, and insufficient support staff. These reasons were reported by 80% of the nursing staff surveyed.

Jones et al. [34], concluding a review of the literature on unfinished care, identify it as a form of medical error classified as underuse, emphasizing the importance of nurse staffing strategies and strengthening teamwork, as well as the ability of direct care nurses to make effective/appropriate decisions when time is scarce. Lack of nurses' time is a major factor causing unfinished care, with many negative consequences for patients, nurses, and organizations.

An error of omission is different from a mistake; instead, it is the result of a nurse's conscious choice of which activities will not be performed at the right time and which activities will not be performed by her at all due to staffing shortages, excess duties, poor work organization or poor working conditions, or other reasons not on her side. It must be emphasized that omission is a conscious choice of the nurse in question, just as it is a conscious choice to carry out the plan of care. According to Jones et al. [34], unfinished care consists of 3 stages: (1) the occurrence of a problem related to a lack of or difficulty in implementing care due to a shortage of resources or time; (2) the process by which priorities are set in relation to stage one in which the decision to ration care is made; and (3) the inadequate outcome or lack of care.

However, there are errors of omission, initially conscious, later unconscious due to habits; since there is always/usually no time to perform the activities in question, then their non-performance or delay becomes obvious, then such a condition becomes a habit, and unconsciously the activities in question are missed. Once care is missed, and there is no apparent detrimental effect on the patient, or it goes unnoticed by others, it makes it easier to decide to delay or miss that element of care next time. As Kalisch et al. [4] suggest, these habits can be so deeply ingrained that nurses no longer make conscious decisions to omit care. Care will be missed, patient by the patient, unless the omission is noticed and acted upon.

Papastavrou et al. [35] emphasize that hidden ethical aspects are the most problematic, which in nursing practice means the need to conduct research in this area and take action to reveal hidden ethical aspects. In nursing work, in addition to errors of omission/delay, there are, for the same reasons as rationing nursing care or similar, other irregularities: errors and mistakes, which further exacerbate the effects of rationing. These other errors and mistakes, unlike errors of omission/delay, are not conscious when they occur. Their occurrence is also related to work pressures and a flurry of responsibilities.

In nursing care, errors can result from nursing diagnoses that are incorrectly made or not made at all or from a lack of up-to-date knowledge due to low opportunities for continuing education, that is, in general, errors in inference, e.g., poorly selected nursing methods, their frequency or their improper execution. Furthermore, due to shortages of nursing staff, not only is there rationing of nursing care, i.e., conscious choices about which activities will be omitted and which will be delayed but there are also other errors and mistakes. It should also be emphasized that all 32 situations described in the BERNCA-R survey - if they occur in patient care - belong to adverse events. The subject of research by practitioners and theoreticians is assessing the quality of nursing care; hence, dedicated research tools have been developed for this purpose, which will be briefly discussed below.

Methods for assessing the rationing and the quality of nursing care

Jones et al. [34] analyzed concepts relating to care rationing. They conducted a literature review in CINAHL and MEDLINE, which found that unfinished care was surveyed with 14 tools. Most nursing staff (55-98%) reported that they had missed at least one activity, and among unfinished care, education, and emotional support were at a disadvantage compared to activities related to physiological needs or organizational activities.

Among the most commonly used survey methods were:

- BERNCA-R (Basel Extent of Rationing of Nursing Care) – developed by Schubert et al. [3,8], enables the measurement of implicit rationing of nursing care in hospitals.
- MISSCARE (Missed Nursing Care Survey) – developed by Kalisch and Williams [36] - is used to measure missed care and determine the reasons for it. The survey consists of two parts. The first contains 19 elements of nursing care, while the second contains 17 reasons for missed care (related to available staff resources, material resources, and team communication). Responses are given on a four-point Likert scale (ranging from "never" or "rarely" to "skipped always") [4,36].
- PIRNCA (Perceived Implicit Rationing of Nursing Care) – was developed by Jones [9] to measure implicit rationing [9]. Validation of PIRNCA for research in Poland was conducted by Uchmanowicz et al. [37].
- NEWRI (Neonatal Extent of Work Rationing Instrument) – scale for assessing care rationing in the neonatal intensive care unit (NICU). The questionnaire, published by Rochefort et al. [38], consists of 59 items related to nursing activities in neonatal care, of which the following can be distinguished: life support and technology-oriented nursing care (15 items); parental support and teaching and infant care (12 items), patient supervision (7 items); and care coordination and discharge planning (6 items). Each item is rated using a scale of 1-4, where 1 means "very rarely," 2 "rarely," 3 "often," and 4 "very often" [38]. Validation of the Polish version of NEWRI was conducted by Rozensztrauch et al. [39].

- TLU (Tasks Left Undone) – a scale developed by Lucero et al. [6] to examine: "tasks left unresolved" or unmet nursing care needs. In this 12-item scale, nurses identify patient care activities during their last shift that they believe were necessary but which were left undone. In the study by Lucero et al. [6], these were: developing or updating a nursing care plan; comforting/talking to patients; skin care, including back skin; educating patients and their families; documenting nursing care; oral hygiene; and preparing patients and their families to leave the hospital [6].

A review of other available studies for studying the quality of nursing care was conducted by Sierpinska, listing the following [40]:

- QualPaCs (Quality of Patient Care Scale) – scale allows assessing the level of patient care in the bio-psycho-social area;
- TLF (T. Langford Method) – assesses the quality of the nursing process regarding patients' physical needs, treatment, medication administration, spiritual and emotional needs, teaching, post-hospital care, environment, and nursing documentation;
- RMI-MSV (Rush Medicus Nursing Process Quality Monitoring Instrument) – developed to assess the quality of short-term care;
- EQUIHP (European Quality Instrument for Health Promotion) – tool developed to assess the quality of patient care in the area of health promotion;
- InterRAI questionnaire – for assessing the health status and health needs of people in long-term care facilities;
- OIQ (Observable Indicators Quality) – tool developed to assess the quality of nursing care in nursing homes;
- OPPQNCS (Oncology Patients' Perception of the Quality of Nursing Care Scale) – the scale assesses the quality of nursing care for oncology patients;
- PQLI (Palliative Care Quality of Life Instrument) – to assess the quality of care in the terminal phase;
- CECSS (Consumer Emergency Care Satisfaction Scale) – for assessing the quality of nursing care for patients with life-threatening conditions;
- NQS (Nursing Quality Scale) – to assess for proper interpersonal relationships between patient and nurse;
- BOHPISZO (Nursing Care Quality Assessment Sheet) – a tool for assessing the level of nursing in hospital wards (safety, protection against infection, hotel services along with meeting existential needs, information, subjectivity, self-care, therapeutic and nursing procedures, organizing and documenting nursing care).

Other tools that provide information on the work environment affecting the quality of nursing care:

- PES-NWI (Practice Environment Scale of the Nurse Work Environment Index) – a scale for analyzing the work environment (32 questions with a 4-point Likert scale), five subscales assessing the adequacy of human and material resources, cooperation in the treatment team including information flow, support of nurses by managers, and two assessing nurses' participation in hospital management [41,42]. The scale discussed above was used in the RN4CAST project. On the Polish ground, the study included 2605 nurses employed in surgical and internal medicine departments in 30 hospitals [43].
- PES-NWI-R (Practice Environment Scale of the Nurse Work Environment Index-Revised) – a tool to measure nurses' participation in hospital endeavors; adequacy of staffing and resources; basics of nursing care quality; nurses' managerial skills; nurses' leadership and support; nurse-physician relationships. Responses according to a 4-point Likert scale [44].

Main reasons for rationing of nursing care

The best introduction to discussing the causes of nursing care rationing is to present the Missed Nursing Care Model described by B.J. Kalisch [4] in an article on the theoretical analysis of the aforementioned concept. The model includes five areas that influence each other to form a causal sequence leading to delayed/missed care:

1. Factors related to the nurse's work environment (staffing resources, material resources, relationships, teamwork, how the team communicates)
2. Factors related to the nursing process
3. Factors related to management and decision-making processes
4. Factors related to nursing care – provided as planned, delayed, or omitted.

5. Factors related to patient outcomes.

Personnel resources refer to the number and type of nursing positions in terms of competence, education, and experience, but also auxiliary-care personnel available due to patient demand for nursing care. Material resources that affect the ability to provide nursing care are the availability of medicines, medical equipment, and functional facilities. Teamwork and communication among therapeutic team members, between nurses, physicians, and support staff, is to inform the ward nurse or team leader of problems in providing appropriate care.

In summary, when the available staffing and material resources to provide care are incompatible with the required plan of care, nurses must make choices or prioritize their work, with the result that certain activities will be missed or delayed. Another area affecting the delay or omission of elements of patient care is related to the internal, individual values, beliefs, and habits of the nurses themselves, but also the accepted norms and decision-making processes within the team. To illustrate this aspect of delayed care, Kalisch [4] cites George Homans [45], in whose study the issue of norms in the team is presented. Namely, every team has a set of norms for the acceptable behavior of its members. Team norms are usually implicit, but new members learn to accept them relatively quickly, e.g., if new nurses notice that they are omitting an activity and other senior nurses suggest that it can be omitted, then new team members tend to conform to their suggestions, as failure to conform could result in social isolation.

The most commonly cited reason in the literature for rationing nursing care is staffing shortages. For example, Hegney et al. [46], in a cross-sectional study involving nearly 2,400 nurses in Australia, found that between 20 and 40 percent of nurses surveyed reported that they were unable to provide the required care due to insufficient staffing and inadequate skills resulting in excessive workload and rationing of nursing care.

Another reason is overload due to nurses performing activities outside their duties. Al-Kandari et al. [11] found that non-nursing tasks accounted for 21% of the total workload, while nursing tasks accounted for 79% of the workload. The authors point to the association of unfinished care and non-nursing tasks that do not require professional skills and are not related to direct patient care, e.g., coordinating support services and transporting the patient. During the study, a negative correlation was shown between completed tasks and non-nursing tasks, which means that the workload of non-nursing activities should be minimized in favor of nursing care activities. The solution is to increase the number of support staff for non-nursing tasks on all wards and during all shifts.

In a study conducted by Griffiths et al. [47] based on a review of data from the Cochrane Library, CINAHL, Embase, and MEDLINE for quantitative studies of associations between staffing and missed care in acute adult hospitals, 18 studies provided subjective reports of missed care. A 75% or higher proportion of nurses reported a lack of care. A total of 14 studies found that low nursing staffing levels were significantly associated with higher reports of missed care. Among the findings of this study was another - reports of lack of nursing care in hospitals are associated with low nurse staffing levels in the Nurses' Registry.

Blackam et al. [48], in a study they conducted using the MISSCARE, took 17 reasons for nursing care rationing, demographic variables of nursing staff and workplace (e.g., age, gender, nurses' residence, shift work, type of unit, etc.), and a list of omitted activities (created by Kalisch). The researchers looked for what variables affect the incidence of nursing rationing and how they affect each other. Among the causes of missed care, they assumed the following variables:

1. Inadequate number of nursing staff.
2. Situations requiring urgent patient care (e.g., deteriorating patient condition).
3. Unexpected increase in the number of patients.
4. Inadequate number of support and office staff.
5. Inadequate allocation of patients.
6. Inadequate availability of medications when needed.
7. Inadequate transfer from the previous shift or transfer patient to the ward.
8. Failure to provide necessary care by other departments/divisions, e.g., physiotherapists.
9. Failure to make equipment available when needed.
10. Failure to keep equipment in working order when it is needed.
11. Lack of support from team members.
12. Tensions or deficiencies in communication with support departments.
13. Tensions or deficiencies in communication within the nursing team.
14. Tensions or gaps in communication with medical staff.
15. Lack of communication from a nursing assistant or caregiver that required care was not delivered.

16. Unavailability or absence of the nurse designated to care for the patient.
17. High staff turnover in admission and discharge.

Finally, eight reasons for nursing rationing were identified: availability of staff, shift work, allocation of nursing staff - resource allocation, team communication, workload, predictability of workload, nurses' level of satisfaction with their current job, and intention to change jobs. It should be noted that the greater the shortage of personnel and material resources, dissatisfaction with the job, and intention to leave the job, the care rationing was more frequent [48].

Schubert et al. [49], speaking about the causes of nursing rationing (covert rationing), define rationing as "withholding or omitting necessary nursing activities for patients due to lack of resources: personnel, skills and time." Saqer et al. [50] report that the most common reasons for nursing rationing were staffing and material resources, followed by communication.

Aiken et al. [2], in a cross-sectional study in five countries (711 hospitals and more than 43,000 nurses) showed that, among other things, nurses (from 1/3 to more than 2/3 of those participating in the study) performed many functions that do not require special professional training, e.g., housekeeping, transporting trays of food. In contrast, activities requiring their knowledge were not performed because there was no time, e.g., oral care or showing emotional support to patients. Another example is the reduction of nurse managers, which on the one hand, results in nurses involved in direct patient care having less time to care for patients as they take on some of the management responsibilities, on the other hand disrupts the whole concept of nursing management.

Janikova et al. [51] based their study on direct interviews with nurses, looked for causes (related to the professional and private personality of the nurse, the personality of the patient, the health care system, and the management system); the effects of missed care on patients as well as staff; under-performed (missing) interventions (within primary patient care, specialized nursing care, and common activities performed by all those providing patient care), and suggestions for potential solutions including changes in management and marketing, patient and staff education, and patient care.

Personal reasons related to professional and personal characteristics [51]:

- education and related ignorance of specific procedures, seniority, failure to perform (acceptance of stereotypes), and performance of procedures incorrectly learned in another job or school,
- among nurses' personal characteristics are fatigue, current health status, age, and values, e.g., "I consider some things important and some things unimportant," the issue of liking or disliking certain patients, "impatience to work," fear for oneself due to patient aggression, feelings of disrespect and early professional burnout (lack of management support).

Reasons underlying the health care system [51]:

- number of patients per nurse, increased bureaucracy, lack of competence, shortage of nurses, lack of funds for labor resources and staff salaries, poor organization of care (heavy patients staying in general wards requiring specialized procedures with the same number of staff), work overload (shift work, lack of breaks, overtime), many tasks at the same time, e.g., between 6:00-10:00, frequent changes in procedures and medications,
- other reasons include inadequate space layout of wards: lack of individual rooms, inadequate discharge times for patients with diabetes in the late afternoon, for example,
- one of the reasons cited by nurses was also pressure on the profession by the public in terms of quality of care and staff knowledge.

Reasons underlying the management system [51]:

- in this area, according to nurses participating in the survey, the reason for the lack of care was poor management, e.g., increasing demands, lack of praise and recognition, doctors' underestimation of nurses' work, inadequate communication, fear of admitting mistakes, little support for teamwork, and thus lack of agreement within the team,
- a principled approach by management to both staff and patients, lack of support for innovation and improvement, overlooking the mental and spiritual needs of staff.

Reasons underlying the patient's personality [51]:

- the personality and characteristics of the patients can be a reason for the lack of nursing care, even relationships that one likes or dislikes someone. One of the nurses interviewed said an interesting phrase: "Those who do not ask for care do not get it."
- another reason may arise when the patient himself refuses to be cared for or, conversely, demands more care simply because he has paid for an upgraded room, and this behavior does not please the

nurses. Participating nurses, missing interventions in care, described them as not life-threatening to the patient but difficult to detect and check, even those requested by the patient,

- the rush to perform various activities, which is negatively perceived by patients and adversely affects the correctness of a given activity, such as changing a dressing.

Summary

The available literature points to the most commonly cited reasons for unfinished care, which include lack of teamwork, the inadequacy of resources, poor safety levels, and nursing shortages. Personnel resources refer to the number and type of nursing positions in terms of competence, education, and experience, but also auxiliary-care personnel available due to patient demand for nursing care. Material resources that affect the ability to provide nursing care are the availability of medicines, medical equipment, and functional facilities. Teamwork and communication among therapeutic team members, between nurses, physicians, and support staff, is to inform the ward nurse or team leader of problems in providing appropriate care. The most commonly cited reason in the literature for rationing nursing care is staffing shortages. Another reason is overload due to nurses performing activities outside their duties. One of the solutions is to increase the number of support staff for non-nursing tasks on all wards and during all shifts. The second part of this topic series will address the nursing shortages and demand for nursing care, the effects of inadequate nursing care on patients and nursing staff, and the economic and social effects of inadequate nursing care.

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