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Original research article

Unfinished nursing care – the first pilot study in the Czech Republic

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Abstract
Aim: The main aim of this pilot study was to investigate the amount, type and reasons for unfinished nursing care among Czech hospital nurses. The other aim was to compare the differences in the level of unfinished nursing care according to age, perceived lack of staffing and job satisfaction of nurses.
Design: A descriptive cross-sectional study.
Methods: A self-reported PIRNCA (Perceived Implicit Rationing of Nursing Care) instrument was used to measure unfinished nursing care. A sample included 100 hospital bedside nurses from two different hospitals in the Moravian-Silesian Region, Czech Republic. Data were collected in 2017.
Results: Elements of care most frequently left unfinished were: Timely response to patient/family request, Provide adequate supervision, Emotional or psychological support, Monitoring a patient's behavior, and Reviewing multidisciplinary patient documentation. Nurses reported the most common reasons for unfinished nursing care to be: inadequate number of nursing staff. The most differences in the level of unfinished nursing care were found to be dependent on perceived lack of staffing.
Conclusions: This pilot study also revealed the existence of hidden phenomenon in Czech clinical practice. According to the results of this pilot study there are differences in the level of unfinished nursing care according to age, perceived lack of staffing and job satisfaction of nurses.

Keywords: Hospital nurses; Lack of staffing; Survey; Unfinished nursing care

Introduction

Nursing shortage matters lead to increased awareness of that form of underuse, and lean staffing practices enhanced an investigation movement of the new phenomenon (Aiken et al., 2001a). This phenomenon is in the literature known as missed nursing care (Kalisch, 2006), unfinished nursing care (Sochalski, 2004), implicit care rationing (Schubert et al., 2007; 2008), task incompletion (Al-Kandari and Thomas, 2009), unmet nursing care needs (Lucero et al., 2009), care left undone (Ausserhofer et al., 2014), the unfinished task of nursing care (Kebede et al., 2017) and others. "The greatest potential danger with the current drive to decrease costs through reduction in nurses is the inability to maintain a high standard of quality and safe patient care" (Tschannen and Kalisch, 2009). Unfinished nursing care is a significant aspect of the overall quality of nursing care and patient safety in acute care hospitals (Jones et al., 2015). Theoretically it is a type of error that may have negative effects on patients. Hospitals have to strive to provide consistently high quality care in a fast changing environment. It is now more common than before for the media to inform about the risk of nursing shortages in hospital – as well as about their serious effects on quality of care (Aiken et al., 2001b).

Unfinished nursing care is "a prevalent form of medical error categorized as underuse" (Jones et al., 2015). According to Papastavrou et al. (2014), nursing care rationing is a significant threat to patient safety and quality of care. It refers to "how nurses are forced to ration their attention across their patients and how they prioritize the everyday delivery of care in clinical practice".

Implicit rationing of nursing care (Schubert et al., 2007) was chosen as the conceptual framework for this study. The phenomenon of implicit rationing of nursing care was first measured using BERNCA (the Basal Extent of Rationing of Nursing Care) developed in Switzerland by Schubert et al. (2007). The BERNCA contained 20 items representing activities within the domain of nursing practice for nurses in Swiss hospitals. The prompt for direct care provider respondents was selected as follows: "how often during the last seven working shifts were you unable to perform the listed activities when needed?" (Schubert et al., 2013) The response options were: "never", "rarely", "sometimes", and "often". Subsequent re-

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vised instrument (BERNCA-R) included an additional 12 new items and a response option of "not required". The reliability of the revised instrument (BERNCA-R) was proved as high with Cronbach α = 0.94 (Schubert et al., 2013).

Jones (2014) adapted BERNCA instrument to US clinical environment and published PIRNCA (Perceived Implicit Rationing of Nursing Care). The adapted instrument PIRNCA involved some changes related to inclusion of tasks more common for nursing practice in the USA. The PIRNCA contains 31 items. The prompt for respondents as well as response options are the same as in BERNCA. The PIRNCA was evaluated in a stratified random sample of 226 medical surgical nurses in U.S. hospitals. Nurses rated how often they were unable to finish each nursing activity for patients when needed within the previous seven working shifts. The PIRNCA instrument demonstrated high reliability and internal consistency with Cronbach's α = 0.97 (Jones, 2014). In this study we used the PIRNCA instrument for measuring unfinished nursing care. The PIRNCA instrument has not been tested yet in Europe. As this is a relatively new area of research in nursing, there are limited published research studies on the issue from the central European clinical environment. In the Czech Republic there are only a few papers focusing on the topic of unfinished nursing care so far (Kalánková et al., 2019; Zeleníková et al., 2019).

Materials and methods

Aim

The main aim of the pilot study was to investigate the amount, type and reasons for unfinished nursing care among Czech hospital nurses. The other aim was to compare the differences in the level of unfinished nursing care according to age, perceived lack of staffing and job satisfaction of nurses.

Design

A descriptive cross-sectional study.

Sample

A sample included 100 hospital bedside nurses from two different hospitals in the Moravian-Silesian Region, Czech Republic. Both selected hospitals are large hospitals with more than 600 beds. Inclusion criteria for nurses: nurses with at least one year working experience, providing direct care to patients on medical-surgical standard units or ICU. Exclusion criteria: nurse managers. Most of the nurses (89%) worked at standard units of a medical-surgical department. 58% of nurses usually worked forty and more hours per week. The majority of the sample (95%) has no intention of leaving the nursing profession, but 32% want to leave their current position in the next years and 8% in the next six months. Characteristics of nurses are contained in Table 1.

Data collection

The primary variable in this study was implicit rationing of nursing care measured by the Czech version of a self-reported PIRNCA instrument, a 31-item inventory of nursing care activities (Jones, 2014). Nurses were required to rate the frequency in which they were unable to complete each activity during the previous seven shifts. Frequency ratings included: not needed (0), never (1), rarely (2), sometimes (3), often (4).

After permission from the author of the original version (Jones, 2014), the PIRNCA instrument was translated from English to Czech language using forward-backward translation and was then reviewed by clinicians. The forward-backward translation included: (1) two translations from English to Czech by two independent translators and creating one forward translation, (2) backward translation from Czech to English by another translator, (3) comparison of the back translation with the original version of the instrument. Then, a panel of 7 nursing experts (bedside nurses and nurse managers) reviewed each item for its clarity and relevance to practice.

During the review of Czech version of PIRNCA instrument by clinicians, for the purpose of this pilot study the suggestion was made to add the quantification to answers as follows: rarely = once or twice; occasionally = three or four times; often = five and more times. Clinicians also recommended adding reasons for unfinished nursing care to the questionnaire.

In addition, reasons of unfinished care were examined on a Likert scale from 0 – 'not a reason' to 10 – 'significant reason'. The higher the score the stronger the reason for unfinished nursing care. Eleven reasons were adapted from MISSCARE Survey (Kalisch and Wiliams, 2009). In the original version 17 reasons were listed.

Demographic data included: age, gender, education level, position at work, type of department, hours usually worked per week, intention to leave the current job position, intention to leave the nursing profession, perceived lack of staffing. Job satisfaction was assessed using the single item (How satisfied are you with your current nursing job?) on a scale from 0 (It is terrible) to 10 (I love it).

Data were collected in May and June 2017. Respondents were approached during their shifts. Completion of the questionnaire was considered as informed consent. The return rate was 71%.

Data analysis

Descriptive statistics such as percentage, mean, median, and standard deviation were used to describe the sample characteristics as well as responses to each item of the questionnaire. The data from PIRNCA were analysed to determine: the mean of individual item score, the percentage of nurses reporting at least one element of care being left unfinished. For statistical reason some variables were dichotomized. The variable "job satisfaction" was dichotomized to represent nurses less satisfied with their job (0–6) versus very satisfied nurses (7–10). The variable "perceived lack of staffing" was dichotomized to represent nurses perceived lack of staffing more than 50% of time versus nurses perceived lack of staffing 50% of the time and less. The variable age was divided into three groups: 21–30 years, 31–40 years and 41 years and more.

Wilcoxon test for two samples and Kruskal–Wallis test for more groups were used to compare the differences in the level of unfinished nursing care according to age, perceived lack of staffing and job satisfaction.

Statistical significance were set at p-value < 0.05. All statistical analyses were carried out using statistical program Stata v. 13.

Results

The average age of nurses was 35.7 years. Most of the nurses worked at standard units. Forty percent of nurses perceived there to be a lack of staffing 75% of time, and thirteen percent of nurses perceived there to be a lack of staffing 100% of time (Table 1).

Table 1. Sample characteristics (*N* = 100)

Characteristics		%
Gender	Women	98%
	Men	2%
Highest education level	secondary nursing school	59%
	higher nursing diploma school	16%
	bachelor's degree in nursing	20%
	master's or higher degree in nursing	2%
	master´s or higher degree outside of nursing	3%
Position at work	nurse	71%
	nurse specialist	20%
	nurse manager	9%
Type of department	standard unit (medical-surgical)	89%
	intensive care unit	11%
Hours usually worked per week	less than 40 hours per week	42%
	40 and more hours per week	58%
Intention to leave the current job position	in the next 6 months	8%
	in the next years	32%
	no	60%
Intention to leave the nursing profession	yes	5%
	no	95%
Perceived lack of staffing	100% of the time	13%
	75% of the time	40%
	50% of the time	37%
	25% of the time	8%
	0%	2%
Average age (mean ± *SD*)	35.7 ± 8.39 years	

Elements of care most frequently left unfinished were: Timely response to patient/family request, Provide adequate supervision, Emotional or psychological support, Monitoring a patient's behavior, and Reviewing multidisciplinary patient documentation. The mean item score for these elements ranged from 2.74 to 2.18. Elements of care least frequently left unfinished were: Important conversation with an external agency, Administer enteral or parenteral nutrition, Adhere to infection control guidelines, Administer medications, Provide wound care, Prepare patients for treatments, tests, or procedures. The mean item score for these elements ranged from 1.10 to 1.44 (Table 2).

In the current study, dichotomized scoring revealed that a high percentage of nurses left one or more elements of care unfinished. One element of care [Keep a patient or family member waiting longer than 5 minutes when a request was initiated] was also reported left unfinished by a high percentage of nurses (94%).

The most common reasons of unfinished nursing care reported by nurses were: inadequate number of nursing staff (7.2); inadequate number of assistive personnel (6.8); unexpected patients' admission and discharge (6.4); urgent patient situations (6.4); unbalanced patient assignments during shift (5.5) (Table 3).

In terms of job satisfaction, the sample of nurses was dichotomized in two groups: less satisfied with their job (scored 0–6), and very satisfied with their job (scored 7–10). Nurses who were less satisfied with their job reported significantly more unfinished care in the following three activities: routine hygiene for patients; change soiled bed linen, and mobilize or change the position of a patient (Table 4).

For the purpose of statistical analysis, the sample was divided into three groups according to age: 21–30 years (n = 34), 31–40 years (n = 35) and 41 years and more (n = 26). Several statistically significant differences have been found in the level of unifinished care in relation to nurses' age. Younger nurses reported significantly more unfinished care, for example, in the following activities: administer medications, adhere to infection control guidelines, timely response to patient/family request. In these cases, the younger the nurse the more unfinished care there was left (Table 5).

Variable perceived lack of staffing was dichotomized: more than 50% of the time (n = 52) and 50% of the time and less (n = 47). The most differences in unfinished care were found to be dependent on perceived lack of staffing. In all eight nursing tasks presented in table 6, nurses who perceived there to be a lack of staffing more than 50% of the time reported more care left unfinished (Table 6).

Discussion

Although there are increasing numbers of studies worldwide addressing the issue of unfinished/rationed/missed care, in the Czech Republic there is only one published research study with the results of MISSCARE survey so far (Zeleníková et al., 2019). The aim of this pilot study was to investigate the amount, type and reasons of unfinished nursing care among Czech hospital nurses. The results of our study confirmed the statement of Jones et al. (2015) that the reality of unfinished care in a practice setting cannot be denied. Also, this pilot study revealed the existence of hidden phenomenon in Czech clinical practice. Jones et al. (2015) identified that the elements of care least frequently left unfinished fell into the following categories: infection control; nutrition; elimination; and treatments, tests, and procedures. Our results are in congruence with this. The least frequently nursing activities left unfinished were: Important conversation with an external

Table 2. PIRNCA items in the pilot Czech sample

Items (abbreviated)	Mean ± *SD*	Median	2–4*
Timely response to patient/family request (less than 5 min)	2.74 ± 0.84	3	94%
Provide adequate supervision	2.31 ± 0.92	2	83%
Emotional or psychological support	2.27 ± 1.10	2	78%
Monitoring a patient's behavior	2.22 ± 0.97	2	80%
Review multidisciplinary patient documentation	2.18 ± 0.95	2	76%
Document all of the nursing care	2.06 ± 0.92	2	71%
Evaluate the plan of care	2.06 ± 1.02	2	68%
Follow-up on patient status changes, unanswered requests for patient intervention	2.02 ± 0.96	2	72%
Patient and family teaching	2.01 ± 0.89	2	72%
Mobilize or change the position of a patient	1.99 ± 0.82	2	69%
Change soiled bed linen	1.99 ± 0.86	2	69%
Assist a patient with required ambulation	1.97 ± 1.02	2	65%
Document all of your assessment and monitoring activities	1.92 ± 0.82	2	69%
Monitoring a patient's physical safety	1.90 ± 0.91	2	69%
Timely assistance with bowel or bladder elimination	1.80 ± 0.80	2	60%
Monitoring a patient's physiological status	1.80 ± 0.95	2	54%
Assist patients with the intake of food or fluids	1.78 ± 0.94	2	59%
Important conversation with another member of a patient's multidisciplinary team	1.77 ± 1.08	2	67%
Document the initiation or revision of a patient's plan	1.76 ± 0.91	2	63%
Implement measures to promote physical comfort	1.76 ± 0.81	2	61%
Routine hygiene for patients	1.74 ± 0.85	2	60%
Routine skin care for patients	1.74 ± 0.85	2	60%
Adhere to guidelines for safe patient handling	1.72 ± 1.03	2	54%
Important conversation with a patient or family member	1.70 ± 0.83	2	64%
Change intravenous access sites, tubing, and/or dressings	1.54 ± 0.80	1	45%
Prepare patients for treatments, tests, or procedures	1.44 ± 0.67	1	43%
Provide wound care	1.44 ± 0.66	1	41%
Administer medications	1.40 ± 0.80	1	32%
Adhere to infection control guidelines	1.37 ± 0.71	1	36%
Administer enteral or parenteral nutrition	1.27 ± 0.76	1	31%
Important conversation with an external agency	1.10 ± 1.16	1	32%

A mean score of: 1 = never; 2 = rarely (once or twice); 3 = occasionally (three or four times); 4 = often (five and more times).
* Percentage of nurses leaving at least one element of care unfinished (scored from 2 to 4 = more than never).

Table 3. The most common reasons of unfinished nursing care

	Reason	Mean* ± *SD*	Median
1.	inadequate number of nursing staff	7.2 ± 2.46	7
2.	inadequate number of assistive personnel	6.8 ± 2.56	7
3.	unexpected patients' admission and discharge	6.4 ± 2.57	7
4.	urgent patient situations (patient's condition worsening)	6.4 ± 7.58	5
5.	unbalanced patient assignments during shift	5.5 ± 2.66	6
6.	communication problems with medical staff in ward	4.3 ± 2.24	4
7.	inadequate hand off from previous shifts or sending unit	3.7 ± 2.54	3
8.	supplies/equipment not available or not functioning properly when needed	3.3 ± 2.19	3
9.	communication problems within the nursing team	2.9 ± 2.08	2
10.	lack of support from team members	2.9 ± 2.08	2
11.	nursing assistant did not communicate that care was not provided	2.5 ± 2.17	2

* scale (0 – not a reason, 10 – significant reason).

Table 4. Differences in unfinished care in relation to job satisfaction

Nursing interventions	Job satisfaction	Mean ± *SD*	Median	*p*-value
Routine hygiene for patients	0–6* (*n* = 51)	1.9 ± 0 .78	2.0	0.0493
	7–10** (*n* = 48)	1.6 ± 0.90	1.4	
Change soiled bed linen	0–6 (*n* = 51)	2.2 ± 0.87	2.0	0.0191
	7–10 (*n* = 48)	1.8 ± 0.80	2.0	
Mobilize or change the position of a patient	0–6 (*n* = 51)	2.2 ± 0.83	2.0	0.0062
	7–10 (*n* = 48)	1.8 ± 0.76	2.0	

* less satisfied; ** very satisfied.

Table 5. Differences in unfinished care in relation to age

Nursing interventions	Age (in years)	Mean ± *SD*	Median	*p*-value
Administer medications	21–30 (*n* = 34)	1.7 ± 0.91	2	0.0183
	31–40 (*n* = 35)	1.4 ± 0.82	1	
	41 and more (*n* = 26)	1.0 ± 0.45	1	
Adhere to infection control guidelines	21–30 (*n* = 34)	1.6 ± 0.65	2	0.0471
	31–40 (*n* = 35)	1.2 ± 0.71	1	
	41 and more (*n* = 26)	1.3 ± 0.75	1	
Monitoring a patient's physical safety	21–30 (*n* = 34)	1.7 ± 0.75	2	0.0381
	31–40 (*n* = 35)	2.3 ± 1.06	2	
	41 and more (*n* = 26)	1.7 ± 0.80	2	
Timely response to patient/family request	21–30 (*n* = 34)	3.1 ± 0.81	3	0.0053
	31–40 (*n* = 35)	2.9 ± 0.69	3	
	41 and more (*n* = 26)	2.3 ± 0.83	2	
Document all of the nursing care	21–30 (*n* = 34)	2.1 ± 0.89	2	0.0102
	31–40 (*n* = 35)	2.4 ± 0.95	2	
	41 and more (*n* = 26)	1.6 ± 0.70	2	

Table 6. Differences in unfinished care in relation to perceived lack of staffing

Nursing interventions	Perceived lack of staffing	Mean ± *SD*	Median	*p*-value
Change soiled bed linen	more than 50% of time (*n* = 52)	2.2 ± 0.90	2	0.0254
	50% of time and less (*n* = 47)	1.8 ± 0.77	2	
Assist patients with the intake of food or fluids	more than 50% of time (*n* = 52)	2.0 ± 0.86	2	0.0119
	50% of time and less (*n* = 47)	1.6 ± 0.97	1	
Administer enteral or parenteral nutrition	more than 50% of time (*n* = 52)	1.5 ± 0.70	1	0.0026
	50% of time and less (*n* = 47)	1.0 ± 0.78	1	
Emotional or psychological support	more than 50% of time (*n* = 52)	2.5 ± 1.09	3	0.0306
	50% of time and less (*n* = 47)	2.0 ± 1.06	2	
Monitoring a patient's physiological status	more than 50% of time (*n* = 52)	2.0 ± 0.96	2	0.0151
	50% of time and less (*n* = 47)	1.06 ± 0.90	1	
Monitoring a patient's physical safety	more than 50% of time (*n* = 52)	2.1 ± 1.0	2	0.0312
	50% of time and less (*n* = 47)	1.7 ± 0.76	2	
Document all of your assessment and monitoring activities	more than 50% of time (*n* = 52)	2.1 ± 0.78	2	0.0184
	50% of time and less (*n* = 47)	1.7 ± 0.83	2	
Document all of the nursing care	more than 50% of time (*n* = 52)	2.3 ± 0.84	2	0.0116
	50% of time and less (*n* = 47)	1.9 ± 0.96	2	

agency, Administer enteral or parenteral nutrition, Adhere to infection control guidelines, Administer medications, Provide wound care, Prepare patients for treatments, tests, or procedures. Nurses obviously tried to complete these activities first.

In a work environment characterized by time scarcity, nurses are supposed to complete as many activities as possible. Therefore it is obvious that they prioritize some activities over others. Prioritization of physiological needs above emotional and psychological needs is in agreement with Maslow´s hierarchy of needs (Jones, 2016). During the educational process, Czech nurses are taught the Maslow approach so they are exposed to this philosophy and also continue with this approach in clinical practice. In this pilot study, activities of Czech nurses most frequently unfinished were nursing tasks related to the emotional and psychological needs of patients – as well as activities of documentation and supervision. According to Hendry and Walker (2004), priority setting, defined as "the ordering of nursing problems using notions of urgency and/or importance, in order to establish a preferential order for nursing actions, is an important skill in nursing, and a skill deficit can have serious consequences for patients". Also, Jones et al. (2015) emphasized that unfinished care is primarily driven by time scarcity. When there is a scarcity of resources, nurses need to set priorities. "Having to make decisions prioritising different patient care needs, dealing with conflicting expectations or urgency of needs, challenges nurses' professional and moral values" (Suhonen et al., 2018). When nurses experience demands on their nursing care activities which exceed their limited time, 'rationing' has to appear. In a clinical environment this rationing is not possible without prioritization (Hendry and Walker, 2004).

The other aim of the pilot study was to compare the differences in the level of unfinished nursing care according to age, perceived lack of staffing and job satisfaction of nurses. The most differences in the level of unfinished nursing care were found to be dependent on perceived lack of staffing. In our research we found that those nurses who perceived lack of staffing more than 50% of the time reported a significantly higher level of unfinished care in eight activities. Among them, in addition to 'Emotional or psychological support' and 'Documentation', there are also activities focused on the physiological needs of patients: 'Administer enteral or parenteral nutrition', 'Monitoring a patient's physiological status', 'Assist patients with the intake of food or fluids'. These results can show that lack of staffing threatens not only lower priority activities, but also high priority nursing tasks. Prioritizing these activities can lead to moral distress (Choe et al., 2015). Various factors may influence priority setting: the expertise of the nurse; the patient's condition; the availability of resources; ward organization; philosophies and models of care; the nurse-patient relationship; and the cognitive strategy used by the nurse to set priorities (Hendry and Walker, 2004). Lack of labor resources was also the most reported reason for unfinished nursing care. This result is not surprising as similar results were found in the work of Kalisch et al. (2009). Lack of nurses seems to be one of the main antecedents of unfinished nursing care that Czech nurses perceived the most. Further research will help to confirm this hypothesis in the Czech clinical environment.

Limitations

The main limitation was the small non-representative sample of nurses. Subsequent research will be conducted on a larger sample of nurses from more health care facilities. The larger sample will also enable the testing of the psychometric properties of the instrument.

Conclusions

The results of the pilot study using PIRNCA instrument outlined that unfinished nursing care is – to a certain extent – also a problem in the Czech health care setting. Lack of labor resources was the most reported reason for unfinished nursing care. In this pilot study, there are differences in the level of unfinished nursing care according to age, perceived lack of staffing and job satisfaction of nurses. As this is the first study on the implicit rationing of nurses using PIRNCA instrument in the Czech Republic, more research is needed to investigate the determinants of this hidden phenomenon.

Conflict of interest

The authors have no conflict of interest to declare. The study was approved by the Ethical committee of the Faculty of Medicine, University of Ostrava, Czech Republic.

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Nedokončená ošetřovatelská péče – první pilotní studie v České republice

Souhrn

Cíl: Hlavním cílem této pilotní studie bylo zjistit rozsah, typ a důvody nedokončené péče mezi českými sestrami pracujícími v nemocnicích. Dalším cílem bylo srovnat rozdíly v úrovni nedokončené ošetřovatelské péče dle věku, vnímání nedostatku personálu a pracovní spokojenosti.

Design: Deskriptivní průřezová studie.

Metody: Na měření nedokončené ošetřovatelské péče byl použit sebeposuzovací dotazník PIRNCA (Perceived Implicit Rationing of Nursing Care – Vnímání implicitního přidělování ošetřovatelské péče). Soubor tvořilo 100 sester ze dvou vybraných nemocnic Moravskoslezského kraje v České republice. Sběr dat probíhal v roce 2017.

Výsledky: Nejčastěji nedokončenými činnostmi ošetřovatelské péče byly: včasná reakce na požadavky pacienta/rodiny, poskytování dostatečného dohledu, emoční nebo psychologická podpora, monitorování citového stavu a chování pacienta a přezkoumání zdravotnické dokumentace/záznamy celého multidisciplinárního týmu. Sestry jako nejčastější důvod nedokončené ošetřovatelské péče uvedly nedostatečný počet sester. Nejvíce rozdílů v úrovni nedokončené ošetřovatelské péče bylo zjištěno v závislosti na vnímání nedostatku personálu.

Závěry: Tato pilotní studie poukázala na existenci skrytého fenoménu nedokončené péče také v české klinické praxi. Z výsledků studie dále vyplývá, že existují rozdíly v hodnocení nedokončené ošetřovatelské péči v závislosti na věku, pracovní spokojenosti a vnímání nedostatku sester.

Klíčová slova: nedokončená ošetřovatelská péče; nedostatek personálu; průzkum; sestry v nemocnicích

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