



Original research article

Missed nursing care in Brazilian hospitals

Diana Albuquerque Alvim de Paula¹, Adrize Rutz Porto², Maria Cristina Soares Rodrigues³,
Paula Roberta Silva Araújo Machado³, Lucas da Silva Dellalibera², Nádia Fontoura Sanhudo¹,
Herica Silva Dutra^{1*}

¹ Federal University of Juiz de Fora, College of Nursing, Minas Gerais, Brazil

² Federal University of Pelotas, College of Nursing, Rio Grande do Sul, Brazil

³ University of Brasília, College of Nursing, Distrito Federal, Brazil

Abstract

Introduction: Missed nursing care refers to nursing activities that are omitted or delayed; it is recognized as a global issue with potential consequences for patient safety, including an increased risk of adverse events. Universal access healthcare is predominant in the Brazilian health system.

Aim: To describe missed nursing care and its reasons in Brazilian hospitals.

Methods: A multicenter descriptive study was conducted in three teaching hospitals at different Brazilian regions, involving 429 nursing professionals. Data were collected using the MISSCARE-BRASIL instrument.

Results: The most missed nursing care activities were ambulation (57.1%) and participation in interdisciplinary team discussions. The main reasons for missed nursing care were unexpected increases in patient volume and/or acuity (76.5%), and inadequate staffing (75.6%), predominantly within the material resources ($\mu = 2.85$) and labor resources ($\mu = 2.76$) domains. Multivariate analysis showed that staffing inadequacy and job dissatisfaction ($p < 0.001$) were associated with missed nursing care.

Conclusion: Missed nursing care in Brazilian hospitals is associated with limitations in human and material resources, workload overload, staffing inadequacy, and job dissatisfaction, highlighting the need for staffing models adjusted to patient acuity, improved resource management, and organizational strategies to enhance job satisfaction and care quality.

Keywords: Missed nursing care; Nursing; Nursing care; Patient safety; Quality of health care

Introduction

The nursing work environment is often fast-paced and unpredictable, with multiple demands and insufficient resources, which can lead to missed nursing care in essential activities (Pereira Lima Silva et al., 2020; Silva et al., 2021). Missed nursing care refers to nursing activities that are either partially or fully missed or delayed (Chaboyer et al., 2021; Chegini et al., 2020; Dutra et al., 2019; Falk et al., 2022; Imam et al., 2022; Lima et al., 2020; Oliveira et al., 2022; Pereira Lima Silva et al., 2020; Silva et al., 2021). Missed nursing care can occur in fundamental aspects necessary to maintain the patient's health and well-being, such as medication administration and hygiene, assistance with feeding, assessment of vital signs, and addressing any immediate health problems. Evidence also suggests that this phenomenon occurs in supportive care, including attention to patients' emotional, psychological, and social needs, provision of emotional support to family members, planning for patient discharge, reassessment of patients, evaluation of medication effects, and participation in interdisciplinary care discussions (Ahansaz et al., 2024).

Several factors contribute to missed nursing care, including nurse-to-patient ratio imbalances, increased patient volumes, and workload overload (Dutra et al., 2019; Falk et al., 2022; Imam et al., 2022). Staffing, material resources, and communication are the most prevalent factors preventing professionals from delivering all required patient care (Chegini et al., 2020; Dutra et al., 2019; Labrague et al., 2022; Lima et al., 2020).

Prior research also reports that workload complexity and interruptions negatively impact job satisfaction and lead to missed nursing care (Chegini et al., 2020). Work hours and professional experience are key variables influencing missed nursing care, as extended shifts reduce concentration capacity for task completion (Dutra et al., 2019).

Missed nursing care threatens patient safety and nursing care quality (Falk et al., 2022; Imam et al., 2022; Labrague et al., 2022), and is associated with higher risks of adverse events such as falls, pressure injuries, nosocomial infections, medication errors, and even death (Dutra et al., 2019; Kalánková et al., 2020; Lima et al., 2020; Oliveira et al., 2022; Silva et al., 2021).

A review revealed that most studies examining missed nursing care and its associated factors were carried out in European countries and the United States. While missed nursing

* **Corresponding author:** Herica Silva Dutra, Federal University of Juiz de Fora, College of Nursing, Rua José Lourenço Kelmer, s/n – Bairro: São Pedro – Juiz de Fora, Minas Gerais, Brasil; e-mail: herica.dutra@ufff.br
<http://doi.org/10.32725/kont.2026.041>

Submitted: 2025-10-02 • Accepted: 2026-06-28 • Prepublished online: 2026-06-29

KONTAKT 28/3: 262–269 • EISSN 1804-7122 • ISSN 1212-4117

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care likely affects nursing practice worldwide, it remains underreported and understudied in developing nations (Imam et al., 2022). Missed nursing care can be used as an indicator of nursing care quality and a guide for improving hospital safety practices.

Identifying and discussing missed nursing care and its reasons can aid institutional risk management and foster a patient safety culture. Understanding these variables is critical for developing preventive strategies, proposing solutions for care delivery failures, and planning corrective actions to enhance care quality and safety (Labrague et al., 2022; Lima et al., 2020).

However, most studies that evaluated missed nursing care were not developed in universal access healthcare settings. This is a particular trait of the Brazilian healthcare system, where approximately 75% of the population is under the Unified Health System (Sistema Único de Saúde – SUS) assistance (Castro et al., 2019). Thus, this study aims to describe missed nursing care and its reasons in Brazilian hospitals.

Material and methods

Study design

This was a multicenter descriptive study following the “Strengthening the Reporting of Observational Studies in Epidemiology” (STROBE) and “Strengthening tRansparent reporting of reseArch on uNfinished nursing CARE” (RANCARE) guidelines. This study is part of the broader research project titled “Evaluation of the Practice Environment, Missed Nursing Care, and Safety Climate: Perceptions of nursing professionals from three Brazilian regions”.

Sample and setting

The study was carried out in three medium-sized federal teaching hospitals (A, B, C) in Brazil’s Midwest, Southeast, and South regions. These hospitals exclusively assist patients of the Unified Health System, and are managed by the Brazilian Hospital Services Company (Empresa Brasileira de Serviços Hospitalares – EBSERH), serving as referral centers for multiple specialties in their respective regions.

The sample comprised 429 nursing professionals (143 per hospital), including nurses and nursing technicians, working in the study units during data collection. Inclusion criteria were being a nurse or nursing technician; employment at the institution for ≥ 3 months, and not being on leave during data collection. Professionals exclusively performing administrative/managerial roles were excluded. It should be noted that, in Brazil, nurses have a bachelor’s degree which takes four to five years of university study, and nursing technicians complete a secondary-level nursing program, lasting about two years, which combines classroom instruction with supervised clinical training. According to Brazilian law, nursing technicians can provide direct patient care under a nurse’s direct supervision and orientation.

The sample size was calculated using G*Power 3.1.9.3 ($\alpha = 0.05$, $\beta = 0.80$, medium effect size), yielding 143 participants per hospital. Hospitals A and C used random sampling with replacement; Hospital B used convenience sampling due to COVID-19 constraints.

A total of 429 nursing professionals were included. Participants were characterized according to sociodemographic and professional variables. The sample was predominantly female (80%). Most participants were nursing technicians (66.2%), while 33.8% were nurses. Regarding tenure in the unit, 51.7%

had worked up to 3 years and 48.3% for 4 years or more. The majority were aged ≥ 36 years (62.2%), whereas 37.8% were ≤ 35 years. Concerning the perceived inadequacy of staffing levels, 58.5% reported this occurring $\geq 50\%$ of the time, while 41.5% reported $< 50\%$. In relation to experience in the current position, 62.2% had ≥ 10 years, while 37.8% had ≤ 9 years. With respect to workload, 54.5% were assigned ≥ 5 patients per shift and 45.5% were assigned ≤ 4 patients. Most participants held higher education or postgraduate qualifications (70.4%), whereas 29.6% had secondary education. Job satisfaction predominated (82.5%). Only 7% indicated an intention to leave their job. Finally, 60.6% worked day shifts and 36.1% worked night shifts.

Data were collected between October 2018 and April 2019 at Hospital A, from November 2020 to July 2021 at Hospital B, and from July 2021 to September 2022 at Hospital C. For data collection, participants were asked to complete the MISSCARE-BRASIL instrument validated for Brazilian culture (Siqueira et al., 2017).

At Hospital A, participants completed the instrument on researchers’ electronic devices with face-to-face support, and the Informed Consent Form (ICF) was provided in hard copy. At Hospital B, professionals were approached during working hours and, after agreeing to participate, received a link to the instrument via a messaging application, with the ICF delivered in hard copy. At Hospital C, professionals initially received the ICF and questionnaire link by email; due to low adherence, in-person invitations were later conducted when epidemiologically feasible, and access was subsequently provided via a messaging application. Differences in data collection methods and periods across hospitals were due to COVID-19-related restrictions and funding limitations.

Data was collected using the KoboToolbox software (Das, 2024). The participants could clarify any questions about the Kobotoolbox software or the research questionnaire with the research team at Hospitals A and B. The researchers’ contact details were made available at Hospital C.

Data collection tools

MISSCARE-BRASIL was the instrument used for data collection. The participants were asked to give information about their perception of missed nursing care and the reasons for this in the unit where they work. It includes an initial section on participants’ sociodemographic and professional characteristics, followed by two parts with answers on a Likert-type scale. Part A consists of 28 items referring to missed nursing care in a five-point response scale, ranging from “always missed” to “never missed”. Part B has 28 items referring to the reasons for missed nursing care, and the four-point response scale ranges from “significant reason” to “not a reason for missed nursing care”. The reasons are divided into five domains: communication; material resources; labor resources; ethical dimension; and management (Siqueira et al., 2017).

The value of the items of missed nursing care reported by each participant was summed, providing a global score ranging from 28 to 140. Additionally, the mean score of each item and the mean score of each domain were calculated. The mean score of the items and domains could range from 1 to 5. Values lower than three indicate missed nursing care.

Based on the original studies, the transcultural adaptation of the MISSCARE instrument to the Brazilian context ensured conceptual, semantic, and cultural equivalence, as well as an assessment of the internal consistency of the adapted version (Cronbach’s $\alpha = 0.964$ for Part A and 0.924 for Part B) (Siqueira et al., 2013). The evaluation of its psychometric

properties confirmed its reliability for the Brazilian population (Cronbach's alpha >0.70) (Siqueira et al., 2017).

Regarding the Cronbach's alpha values for the communication ($\alpha = 0.57$) and ethical ($\alpha = 0.54$) domains, they indicate moderate to low internal consistency, below the conventional cutoff of 0.70 (Souza et al., 2017). However, these domains encompass complex, multidimensional constructs influenced by contextual and organizational factors, and the limited number of items per domain may have contributed to the lower coefficients (Hair et al., 2018; Souza et al., 2017; Tavakol and Dennick, 2011). In instruments that assess reasons for nursing care omission, the items may represent different facets of the construct, which may limit the correlation between items without necessarily compromising content validity (Tavakol and Dennick, 2011). In this context, alpha values below 0.70 are considered acceptable in exploratory studies, or during instrument adaptation when supported by theoretical justification and evidence of content validity (Tavakol and Dennick, 2011).

Data analysis

Data were exported to Excel for Windows® and analyzed using Statistical Package for the Social Sciences (SPSS) v.30. Descriptive statistics (frequency, percentage, mean, median, quartiles, standard deviation) were applied. Cronbach's alpha for Part B domains in this study were: management (0.92), labor resources (0.85), material resources (0.80), communication (0.57), and ethical dimension (0.54).

The relationship between sociodemographic and professional variables and missed nursing care was evaluated using the Mann-Whitney test. Multivariate linear regression was conducted using the *Enter* method, including variables identified as statistically related in univariate analysis. The model fit was verified using the Hosmer and Lemeshow test ($\chi^2 = 0.122$; $p < 0.001$). Impartial data analysis focused on the study objectives was adopted to minimize biases.

Ethical considerations

The study was approved by institutional review boards (Approval n° 4.256.202, n° 4.376.643, and n° 4.401.315), and ad-

hered to Brazilian and international regulations (Helsinki Declaration). Institutional permission was previously obtained from each institution. The Informed Consent Form (ICF) was obtained from each participant, and data privacy/confidentiality was maintained. The International Committee of Medical Journal Editors (ICMJE) recommendations for the protection of research participants were respected.

Results

We found missed nursing care in the investigated Brazilian hospitals (Table 1). The most frequently reported missed nursing care were ambulation (57.1%), participation in interdisciplinary discussions (53.4%), and sitting the patient out of bed (40.3%). The mean global score of missed nursing care was 52.60 (SD = 15.12; median = 51.00; minimum = 28.00; maximum = 124.00).

The reasons for missed nursing care are shown in Table 2. The most frequently mentioned reasons were an unexpected increase in the volume and/or criticality of patients (76.5%), an inadequate number of care/administrative staff (75.6%), the urgent situation of patients (71.6%), and materials/equipment not working properly (69.2%). Among the MISS-CARE-BRASIL domains, material resources ($\mu = 2.85$) and labor resources ($\mu = 2.76$) presented the highest mean scores, representing the most frequent reasons for missed nursing care.

Sociodemographic and professional variables were related to missed nursing care, which highlighted that being a nurse ($p < 0.001$), age ≤ 35 years ($p = 0.006$), staffing inadequacy ($p < 0.001$), and job dissatisfaction ($p < 0.001$) were related to missed nursing care (Table 3).

The multivariate analysis showed that staffing inadequacy ($p < 0.001$), and job dissatisfaction ($p < 0.001$) are the factors associated with missed nursing care among Brazilian nursing professionals (Table 4). The percent of variability explained was 12% ($R^2 = 0.122$) with adequate model fit ($p < 0.001$).

Table 1. Missed nursing care in Brazilian hospitals (n = 429)

Item	n	%	μ	$\pm$ SD
Ambulation three times per day or as ordered	245	57.1	3.09	1.38
Participation in interdisciplinary team discussions	229	53.4	2.90	1.38
Sitting patient out of bed	173	40.3	2.52	1.22
Discharge planning and education	144	33.6	2.29	1.25
Turning patient every two hours	141	32.9	2.32	1.16
Mouth care	126	29.4	2.10	1.09
Monitoring intake/output	121	28.2	2.09	1.34
Serving meals to self-feeding patients	109	25.4	2.07	1.32
Medication administration within 30 minutes of scheduled time	105	24.5	2.00	1.17
Responding to patient call lights within 5 minutes	100	23.3	1.94	0.98
Perineal care after each elimination	92	21.4	1.88	1.03
Providing emotional support to patient and/or family	80	18.6	1.91	0.92
PRN medication administration within 15 minutes	74	17.2	1.80	0.94
Complete patient chart documentation	70	16.3	1.72	0.87
Airway suctioning	67	15.6	1.80	1.02

Table 1. (continued)

Item	<i>n</i>	%	μ	$\pm$ SD
Focused patient condition reassessment	65	15.2	1.75	0.91
Medication effectiveness evaluation	61	14.2	1.76	0.88
Feeding patient or administering tube feeding	55	12.8	1.67	0.96
Oral or tube hydration	53	12.8	1.68	0.91
Patient assessment each shift	43	10.0	1.57	0.81
Skin/wound care	43	10.0	1.57	0.79
Fall prevention measures	42	9.8	1.57	0.81
Routine and care orientation	41	9.6	1.65	0.78
Bathing/hygiene and pressure injury prevention	38	8.9	1.55	0.86
IV/central line site care	27	6.3	1.45	0.64
Vital signs assessment	21	4.9	1.34	0.63
Blood glucose monitoring	20	4.7	1.32	0.62
Hand hygiene	8	1.9	1.29	0.53

Note: μ – Mean; SD – Standard Deviation; PRN – *Pro re nata* (Latin phrase meaning “when required”); IV – Intravenous

Table 2. Reasons for missed nursing care by domain, reported by participants in Brazilian hospitals (*n* = 429)

Item	<i>n</i>	%	μ	$\pm$ SD
<i>Material resources</i>	–	–	2.85	0.88
Equipment/supplies did not function properly	297	69.2	2.98	1.06
Medications were not available	278	64.8	2.88	1.09
Physical facility is inadequate	272	63.4	2.82	1.13
Equipment/supplies were not available	259	60.4	2.73	1.15
<i>Labor resources</i>	–	–	2.76	0.78
Unexpected increase in patient volume and/or acuity	328	76.5	3.10	1.06
Inadequate number of care/administrative staff	323	75.6	3.10	1.09
Emergency situation of patients	307	71.6	3.03	1.08
Inadequate number of staff	292	68.1	2.91	1.14
Large number of admissions and discharges	243	56.6	2.65	1.11
High number of professionals working while sick	229	53.4	2.56	1.15
High number of inexperienced nurses	201	46.9	2.35	1.13
The professional has more than one job	197	45.9	2.41	1.15
<i>Management</i>	–	–	2.57	0.98
Lack of in-service training about required care	257	59.9	2.68	1.14
Nurses unprepared to lead, supervise, and coordinate teamwork	246	57.3	2.63	1.13
Demotivation due to low salary or lack of recognition	204	47.6	2.39	1.20
<i>Communication</i>	–	–	2.56	0.87
Lack of standardization for care delivery	260	60.6	2.71	1.08
Tension/conflict or communication problems with other departments	249	58.0	2.66	1.08
Tension/conflict or communication problems with the medical team	248	57.8	2.68	1.12
The distribution of patients per professional is unbalanced	247	57.6	2.64	1.14
Other professionals did not provide assistance	245	57.1	2.64	1.12
The nursing assistant did not report that care was not performed	222	51.7	2.59	1.17
Inadequate shift handover	216	50.3	2.51	1.14

Table 2. (continued)

Item	<i>n</i>	%	μ	$\pm$ SD
Team members do not work collaboratively	205	47.8	2.38	1.19
Tension/conflict or communication problems within the nursing team	202	47.1	2.45	1.17
The professional responsible for care was unavailable	198	46.2	2.38	1.22
<i>Ethical dimension</i>	–	–	2.51	1.11
The professional who missed nursing care has no fear of punishment/dismissal due to job stability	223	52.0	2.53	1.24
Lack of ethical posture, commitment, and involvement	215	50.1	2.52	1.23
The nursing professional is negligent	206	48.0	2.48	1.25
<i>Note:</i> μ – Mean; SD – Standard Deviation				

Table 3. Relationship between personal and professional characteristics of participants and summary score of missed nursing care (*n* = 429)

Variables	Q1	Median	Q2	<i>p</i> -value*
Sex				
Female	41.00	51.00	61.00	0.809
Male	40.00	51.00	63.00	
Professional category				<0.001
Nursing technician	39.00	49.00	59.05	
Nurse	42.70	56.00	65.00	
Time working in the unit				0.389
Up to 3 years	40.00	51.00	61.75	
4 years or more	42.00	51.00	61.00	
Age				0.006
Up to 35 years	43.00	55.00	63.00	
36 years or older	39.00	48.50	60.75	
Perceived inadequacy of staffing levels				<0.001
<50% of the time	38.00	47.50	58.00	
$\geq$ 50% of the time	43.00	55.00	63.00	
Years of experience in the position				0.584
Up to 9 years	41.00	53.00	63.00	
10 years or more	40.00	51.00	61.00	
Number of patients assigned per professional				<0.001
Up to 4 patients	38.00	46.00	58.00	
5 or more patients	43.00	55.00	63.00	
Educational level				0.168
Secondary education	38.00	48.00	60.00	
Higher education/Postgraduate	41.00	52.00	62.00	
Job satisfaction				<0.001
Dissatisfied	50.25	59.50	69.00	
Satisfied	39.00	49.00	60.00	
Intention to leave the job				0.191
No	40.00	51.00	61.00	
Yes	44.50	53.00	66.00	
Shift				0.892
Day	41.25	51.00	60.00	
Night	39.50	51.00	63.00	

Note: * Test Mann–Whitney

Table 4. Association between sociodemographic and professional variables and missed nursing care (n = 429)

Variable	B	CI (95%)		p-value*
		Lower	Upper	
Staffing inadequacy	4.353	1.561	7.078	<0.001
Number of patients	3.507	0.618	6.216	0.014
Age	-0.971	-3.572	1.876	0.502
Professional category	3.419	0.461	6.855	0.033
Job satisfaction	-8.939	-12.888	-4.852	<0.001

Discussion

This study showed a predominance of female participants and nursing technicians, reflecting the large representation of nursing technicians in the Brazilian healthcare workforce (Santos et al., 2023). The predominance of women in nursing is historically linked to traditional gender roles, as nursing care was long provided exclusively by women, although the profession has undergone gradual masculinization over the past three decades (Santos et al., 2023; Silva et al., 2021).

The study identified “ambulation three times per day or as ordered” as the most frequently missed nursing care (57.1%). Consistent with our findings, a study conducted in Korea and the United States identified “ambulation three times daily” among the five most frequently missed nursing care activities (Lee and Kalisch, 2021). These findings align with a 2021 systematic review that identified ambulation-related care as one of the most frequently missed nursing care (Imam et al., 2022). Another study reported comparable results, listing “ambulation three times per day or as ordered” and “sitting patients out of bed” among the care activities with the highest omission rates (Lima et al., 2020).

The omission of mobility-related care may lead to complications associated with patient immobility (Dutra et al., 2019). Conversely, mobilization during hospitalization provides multiple benefits: pain relief, reduced risk of deep vein thrombosis, decreased fatigue, prevention of pneumonia recurrence, and improved physical function. Beyond enhancing the quality of life and patient satisfaction, systematic implementation of mobility protocols can yield organizational benefits including reduced length of stay, lower mortality rates, and decreased institutional costs, underscoring the need to develop and implement standardized nursing protocols for this intervention (Lima et al., 2020).

Another care activity with high omission rates (53.4%) was “participation in interdisciplinary team discussions”. This issue is not unique to Brazil, as similar findings have been reported in studies from various countries (Imam et al., 2022; Lee and Kalisch, 2021; Lima et al., 2020).

Although participation in interdisciplinary discussions has been classified as intermediate-priority care, non-participation can impair communication, care planning, and collaborative decision-making, compromising care quality (Dutra et al., 2019; Lima et al., 2020; Oliveira et al., 2022). As a patient safety goal, effective interdisciplinary communication is a fundamental competency for delivering quality care, and its inadequacy may lead to unsafe practices and adverse outcomes (Moreira et al., 2019).

The study revealed that the least missed nursing care activities were routine clinical assessments, while care addressing patients’ physical needs was most frequently missed, re-

flecting care prioritization patterns that may compromise holistic nursing care and which are consistent with findings from high-income countries (Imam et al., 2022). Intermediate-priority interventions were unlikely to result in immediate adverse outcomes when occasionally missed (Oliveira et al., 2022), and routine assessments such as vital signs and blood glucose monitoring were performed more frequently, in line with previous studies (Dutra et al., 2019; Imam et al., 2022; Lee and Kalisch, 2021; Silva et al., 2021).

Among the reasons for missed nursing care identified in this study, labor and material resource factors predominated. These findings corroborate other research demonstrating that these two domains represent the primary causes of missed nursing care, with staffing inadequacy being one of the most debated healthcare challenges for ensuring effective and safe care delivery (Silva et al., 2021).

A transnational study comparing reasons for missed nursing care found that inadequate staffing was the most frequently reported factor by care teams (Lee and Kalisch, 2021). This finding was corroborated by a review study identifying insufficient nursing staff as the primary reason cited by participants, followed by inadequate support staff and unexpected increases in patient volume and/or acuity (Imam et al., 2022).

Insufficient human resources and unexpected increases in patient volume and/or acuity are the most frequently reported reasons for missed nursing care, contributing to care quality deficits, adverse events, and professional dissatisfaction due to workforce overload and elevated nurse-to-patient ratios (Imam et al., 2022; Lima et al., 2020). Adequate human resource allocation and structured workflows can improve care planning, patient education, and emotional support (Dutra et al., 2019).

Material resource management is primarily a nursing responsibility and involves forecasting, supplying, and monitoring the quality, quantity, and use of materials to ensure care quality and avoid interruptions. However, Unified Health System financial constraints (Castro et al., 2019) in many hospitals affect procurement processes, resulting in shortages of medications, supplies, and equipment. In this context, investments in functional material resources may reduce missed nursing care and signal managerial commitment to patient safety and care quality (Lima et al., 2020; Silva et al., 2021).

It is worth noting the ethical and professional implications related to missed nursing care, such as the risk of lawsuits due to failures in care (Wieczorek-Wojcik et al., 2020), as well as the possibility of an increase in institutional costs as a result of the patient length of stay in the healthcare service (Chegini et al., 2020; Lima et al., 2020). For nursing professionals, job dissatisfaction may arise from the awareness that essential patient needs remain unmet, placing the care provided in conflict with the professional values and standards of quality that underpin nursing practice (Chegini et al., 2020).

In this study, being a nurse ($p < 0.001$), age ≤ 35 years ($p = 0.006$), staffing inadequacy ($p < 0.001$), and job dissatisfaction ($p < 0.001$) were related to missed nursing care. Nurses are frequently responsible for both clinical and managerial activities, carrying substantial responsibility for organizational performance, patient outcomes, and the quality and safety of nursing care (Eshetu et al., 2025; Li et al., 2025). This broader involvement in clinical and managerial activities may provide nurses with a more comprehensive understanding of workplace factors associated with missed nursing care, which can explain this result.

Other studies indicated that younger age was associated with missed nursing care (Kassahun et al., 2022; Mainz et al., 2024). A study conducted in two European countries showed that younger nurses reported higher occurrences of missed nursing care than professionals aged 45 years or older. Considering that younger nurses generally have less professional experience, limited clinical exposure may be related to a higher frequency of missed care (Mainz et al., 2024). Furthermore, one study highlighted that age and professional experience significantly contribute to the perception of the phenomenon, with older and more experienced professionals tending to perceive themselves as more competent in patient safety-related aspects (Bragadóttir et al., 2017).

The perception of inadequate staffing, reported by 58.5% of participants, is consistent with one of the recurrent factors described in the literature. When combined with a high patient-to-nurse ratio, it is associated with a higher frequency of missed nursing care. This condition reduces the time available for essential interventions and for the appropriate prioritization of activities (Abawaji et al., 2025; Kassahun et al., 2022; Mainz et al., 2024; Voldbjerg et al., 2025).

Similarly, the fact that 54.5% of professionals were responsible for five or more patients per shift aligns with evidence indicating that high workload and high care demands are strong predictors of missed nursing care. The literature indicates that, as the number of patients per nurse increases, the likelihood of omissions in basic and educational nursing care rises proportionally (Abawaji et al., 2025; Voldbjerg et al., 2025).

The job dissatisfaction reported by participants (17.5%) is also consistent with the literature, which identifies low job satisfaction as a factor associated with missed nursing care. Dissatisfied professionals tend to experience greater occupational strain and lower engagement, negatively affecting the completeness of care. In contrast, job satisfaction is associated with higher engagement, greater commitment to professional responsibilities, and increased focus on patient care (Eshetu et al., 2025; Kassahun et al., 2022). The multivariate analysis confirmed staffing inadequacy and job dissatisfaction as associated factors to missed care among Brazilian nursing professionals ($p < 0.001$), reinforcing the need to face these questions in healthcare hospital settings.

The original contribution of this investigation is based on the particular characteristics of the Brazilian Unified Health System. Despite the context of a universal healthcare coverage and the three hospitals operated within the same health system and shared a common management model, the missed nursing care phenomenon was observed with similar associated factors verified in other settings.

Limitations

The study's main limitations relate to data collection, which was conducted at different times due to restrictions imposed by the COVID-19 pandemic, and to the use of self-reported in-

formation rather than direct observation. From a professional practice perspective, the findings indicate that shortages of labor and material resources may increase the occurrence of missed nursing care, affecting nurses' ability to provide necessary patient care.

Another limitation involves the communication and ethical domains, where Cronbach's alpha values were below the conventional cutoff point of 0.70, possibly due to the complex nature of the constructs evaluated and the number of items these comprised. It is therefore recommended that future studies further evaluate the reliability of these domains using larger samples and complementary psychometric indicators.

Conclusion

The results of this study indicate that missed nursing care in hospitals is associated with limitations in human and material resources; including insufficient staffing, high workloads related to patient acuity, job dissatisfaction, and shortages of equipment and supplies. These findings underscore the need for institutional actions and public policy measures focused on staffing models adjusted to workload and patient severity, appropriate workforce allocation during periods of increased demand, and the maintenance of safe nurse-to-patient ratios. In addition, organizational strategies aimed at improving job satisfaction and providing structured support for less experienced professionals – particularly younger nurses – should be incorporated into human resource management. Investment in preventive equipment maintenance, systematic monitoring of material availability, and the strengthening of interdisciplinary communication are recommended to reduce missed nursing care and enhance the quality and safety of care.

Future research should employ longitudinal designs to track missed nursing care patterns. Additionally, it could further elucidate this phenomenon in primary and ambulatory care settings.

Author contributions

Conception – H.S.D., A.P.R.; Design – H.S.D., A.P.R.; Supervision – H.S.D.; Funding – H.S.D., A.P.R.; Materials – H.S.D., A.P.R.; Data Collection and/or Processing – H.S.D., A.P.R., M.C.S.R., P.R.S.A.M., L.S.D.; Analysis and/or Interpretation – H.S.D., A.P.R., D.A.A.P., M.C.S.R.; Literature Review – H.S.D., D.A.A.P.; Writing – H.S.D., A.P.R., D.A.A.P.; Critical Review – H.S.D., A.P.R., D.A.A.P., M.C.S.R., P.R.S.A.M., L.S.D., N.F.S.

Statement on informed consent and use of artificial intelligence

Informed consent was obtained from all subjects involved in the study. AI or AI-assisted tools were used to check the manuscript for grammar and spelling.

Funding

This work was supported by Coordenação de Aperfeiçoamento de Pessoal de Nível Superior – Brazil (CAPES) – Finance Code 001 and Federal University of Juiz de Fora. The funding agencies did not interfere in any part of the research, including study design; collection, analysis and interpretation of data; writing of the report; and the decision to submit the article for publication.

Conflict of interest

The authors have no conflict of interest to declare.

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