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Review

Unfinished nursing care, missed care, and implicitly rationed care: State of the science review

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ABSTRACT

Objectives: The purposes of this review of unfinished care were to: (1) compare conceptual definitions and frameworks associated with unfinished care and related synonyms (i.e. missed care, implicitly rationed care; and care left undone); (2) compare and contrast approaches to instrumentation; (3) describe prevalence and patterns; (4) identify antecedents and outcomes; and (5) describe mitigating interventions.
Methods: A literature search in CINAHL and MEDLINE identified 1828 articles; 54 met inclusion criteria. Search terms included: implicit ration*, miss* care, ration* care, task* undone, and unfinish*care. Analysis was performed in three phases: initial screening and sorting, comprehensive review for data extraction (first author), and confirmatory review to validate groupings, major themes, and interpretations (second author).
Results: Reviewed literature included 42 quantitative reports; 7 qualitative reports; 1 mixed method report; and 4 scientific reviews. With one exception, quantitative studies involved observational cross-sectional survey designs. A total of 22 primary samples were identified; 5 involved systematic sampling. The response rate was >60% in over half of the samples. Unfinished care was measured with 14 self-report instruments. Most nursing personnel (55–98%) reported leaving at least 1 task undone. Estimates increased with survey length, recall period, scope of response referent, and scope of resource scarcity considered. Patterns of unfinished care were consistent with the subordination of teaching and emotional support activities to those related to physiologic needs and organizational audits. Predictors of unfinished care included perceived team interactions, adequacy of resources, safety climate, and nurse staffing. Unfinished care is a predictor of: decreased nurse-reported care quality, decreased patient satisfaction; increased adverse events; increased turnover; decreased job and occupational satisfaction; and increased intent to leave.
Discussion & conclusions: Unfinished care is a significant problem in acute care hospitals internationally. Prioritization strategies of nurses leave patients vulnerable to unmet educational, emotional, and psychological needs. Key limitations of the science include the threat of common method/source bias, a lack of transparency regarding the use of combined samples and secondary analysis, inconsistency in the reporting format for unfinished care prevalence, and a paucity of intervention studies.
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What is already known about the topic?

- Quality problems associated with underuse of healthcare services are more common than those of overuse and misuse combined.

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- Unfinished nursing care (also known as missed care, implicitly rationed care, and care left undone) is a distinct form of underuse and is a growing healthcare concern internationally.
- The state of the science on unfinished nursing care has not been formally evaluated.

What this paper adds

- Unfinished care is conceptualized as a three-pronged phenomenon consisting of a problem (resource/time scarcity), a process (clinical decision making to prioritize and ration care), and an outcome (care left undone).
- The prevalence of unfinished care is high (55–98%) among nursing staff in acute care hospitals internationally. Prevalence estimates are influenced by characteristics of the instrument used.
- Nurse staffing and work environments are a stronger influence on unfinished care than individual nurse characteristics. Unfinished care has consistently been associated with negative nurse, patient, and organizational outcomes.

1. Introduction/background

Quality problems in healthcare have been classified into three major categories: overuse, underuse, and misuse (Chassin and Galvin, 1998). Underuse occurs when healthcare services that would have produced favorable patient outcomes are not provided. Each failure to deliver beneficial services represents a missed opportunity to improve health outcomes and is a form of medical error (Hayward et al., 2005). Evidence suggests that quality problems associated with underuse of healthcare services are significantly more common than those related to overuse and misuse combined (Reason, 1998). Because of their role in prescribing medical services, physicians have traditionally been viewed as gatekeepers to healthcare. Consequently, the science of underuse has traditionally been physician-centric with an emphasis on issues related to failure to prescribe evidence based interventions. However, the problem of underuse extends beyond physician prescribing practices.

Nurses also function as gatekeepers of healthcare through their roles as planners, coordinators, providers, and evaluators of care. Nurses carry out a myriad of interventions prescribed by other providers to treat illnesses and treatment complications. Nurses also carry out a myriad of nurse-initiated interventions to promote health and manage responses to illness. Therefore, few care processes reach patients without first passing through the hands of nurses. As the major conduit for healthcare services, nurses are instrumental in achieving quality patient outcomes. If the flow of care through nurses to patients is blocked, patients may not receive all services as prescribed by nurses and/or other providers, leaving care processes unfinished. This represents a type of underuse distinct from physician prescribing practices historically unaccounted for in medical error research.

Concerns related to nursing workforce shortages and lean staffing practices have increased awareness of this type of underuse and stimulated a wave of scientific inquiry into the phenomenon (Aiken et al., 2001a). The body of literature related to unfinished nursing care has grown significantly over the last decade and a cursory review suggests that unfinished care is a global problem obscured by inconsistencies in terminology. The first quantitative report of unfinished care came from the International Hospital Outcomes Research Consortium (IHORC) under the term *nursing care left undone* (Aiken et al., 2001b). This term was subsequently used interchangeably with *unfinished care* and *tasks undone* and defined simply as nursing tasks left undone because nurses lack the time to undertake them (Sochalski, 2004). Five additional terms with similar definitions were subsequently introduced: *care left undone* (Ausserhofer et al., 2014) *task incompletion* (Al-Kandari and Thomas, 2009), *unmet nursing care needs* (Lucero et al., 2009), *implicit rationing of nursing care* (Schubert et al., 2007), and *missed nursing care* (Kalisch, 2006).

Given the prevalence of this problem internationally and the quality implications associated with underuse of beneficial healthcare services, a critical evaluation of the state of the science is warranted. Therefore, a comprehensive and integrated review of the literature related to unfinished nursing care was completed. The purposes of this review of unfinished care were to: (1) compare conceptual frameworks; (2) compare and contrast approaches to instrumentation; (3) describe prevalence and patterns; (4) identify antecedents and outcomes; and (5) describe mitigating interventions.

2. Methods

2.1. Literature search

A literature search was conducted as illustrated in Fig. 1. The search was limited to articles published in the English language and in peer reviewed journals; no date restrictions were imposed. Articles were eligible for inclusion if they contained: (1) conceptual definitions and/or concept analyses of terms related to unfinished nursing care in the hospital setting; (2) reports of original qualitative research related to the experience of unfinished nursing care in the hospital setting; (3) reports of original quantitative research related to the prevalence, patterns, correlates, and/or predictors of unfinished nursing care in a hospital setting; (4) reports of original research related to the development and/or psychometric evaluation of instruments to measure unfinished nursing care in a hospital setting; or (5) literature reviews of quantitative and/or qualitative reports related to any aspect of unfinished care in a hospital setting. Fifty-four manuscripts met inclusion criteria (Table 1).

2.2. Study selection and synthesis

This review and synthesis was performed in three phases: initial screening and sorting, comprehensive review for data extraction (first author), and confirmatory review to validate groupings, major themes, and interpretations (second author). Based on the initial screening, the literature was sorted into categories of evidence and research design. Additional sources were retrieved and

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