



Original Article

Medical surgical nurses describe missed nursing care tasks—Evaluating our work environment ^{☆,☆☆,★}



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ABSTRACT

Purpose: The purpose of the study was to explore the nurse work environment by evaluating the self-report of missed nursing care and the reasons for the missed care.

Methods: A convenience sample of medical surgical nurses from four hospitals was invited to complete the survey for this descriptive study. The sample included 168 nurses. The MISSCARE survey assessed the frequency and reason of 24 routine nursing care elements.

Results: The most frequently reported missed care was ambulation as ordered, medications given within a 30 minute window, and mouth care. Moderate or significant reasons reported for the missed care were: unexpected rise in volume/acuity, heavy admissions/discharges, inadequate assistants, inadequate staff, meds not available when needed, and urgent situations.

Conclusion: Identifying missed nursing care and reasons for missed care provides an opportunity for exploring strategies to reduce interruptions, develop unit cohesiveness, improve the nurse work environment, and ultimately leading to improved patient outcomes.

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1. Introduction

The delivery of nursing care in an acute care hospital is complex requiring that individual nurses be competent in a host of areas. Medical/Surgical areas care for patients with multiple co-morbidities requiring nurses to have a broad knowledge base, be competent in a variety of skills, and capable of managing large amounts of information. Thus, nurses are valued for their knowledge and thinking skills in decision-making along with other professions such as lawyers, teachers, and physicians. Nurses join the ranks of “knowledge workers” (Cooper, 2006). The complexity of information influx sets the stage for missed care.

Another layer of complexity to executing patient care is found in the work environment. Previous research has shown that workload complexity and interruptions have a negative impact on job satisfaction, burnout, medication errors, and patient mortality (Clark & Flanders, 2012; Kowinsky et al., 2012; Pearson et al., 2006; Stimpfel, Sloane, & Aiken, 2012). As workload increases, less time is available to complete nursing care or perform care in full (Bogossian, Winters-Chang, &

Tuckett, 2014; Lopez, Gerling, Cary, & Kanak, 2010). Workload complexity may place nurses in a position to make difficult choices on which care elements take priority.

Hospitals are now charged with reducing the length of stay, decreasing hospital acquired infections and preventing readmissions; additional forces impacting the delivery of care (Centers for Medicare & Medicaid Services, 2015). Balancing quality of care with cost reduction also impacts the complexity of delivering nursing care. The hospital quality department tracks many disease related patient processes and outcomes to assess and compare patient outcomes with national benchmarks. In addition, many nursing sensitive indicators are audited at the nursing unit level so that individual units are able to evaluate unit specific processes and outcomes, and address improvements in nursing care. Common examples of nursing sensitive indicators include falls with and without injury, pressure ulcers by stage and hospital acquisition, and medication errors. What is difficult to gather, and in many cases not documented in a way that can be captured, are those nursing care elements that may precede a larger event (Committee on the Work Environment for Nurses and Patient Safety & Board on Health Care Services, 2004; Kalisch & Lee, 2012; Kalisch, Tschannen, & Lee, 2012). Each care element may have a downstream effect if not completed. For example, ambulation as ordered may help a patient maintain balance or regain muscle strength, which if not completed, could increase the fall risk. Lack of attention to mouth care may impact appetite or

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create a higher risk for infection (Quinn et al., 2014). It is these missed nursing care elements, collectively or independently, that may precede a nursing error or a patient event.

The purpose of this study was to examine the nurse work environment by evaluating the self-reported missed nursing care elements and reasons for missed care from nurses on medical surgical units. This information provides additional support to develop and test strategies in the nurse work environment that can contribute to reducing errors and improving hospital and nursing quality indicators.

2. Background

2.1. Missed nursing care

Missed nursing care is defined as elements of nursing care that are not completed (acts of omission) rather than nursing care performed incorrectly (acts of commission) (Kalisch, Landstrom, & Williams, 2009) and according to the Agency for Healthcare Research and Quality is an under recognized factor in patient outcomes (Agency for Healthcare Research and Quality, 2015).

Kalisch et al. (2012) found patient fall rates to be associated with reported missed care ($r = .30$; $p < .01$), ambulation as ordered ($r = .22$; $p < .05$), patient assessment performed with each shift ($r = .09$; $p < .05$), call light response ($r = .22$; $p < .05$), and toilet assistance ($r = .30$, $p < .01$) (Kalisch et al., 2012). These were important findings as this was the first identified connection between a patient event and specific elements of nursing care.

However, consequences of missed care go beyond the immediate and potentially long-term detrimental effect on patients. Higher levels of missed care were found to be positively correlated ($r = .4$; $p < .05$) and the strongest predictor ($\beta = .302$; $p = .000$) of nurses' intention to leave along with self-reported missed work ($\beta = .247$; $p = .034$), age > 35 years, and overtime, which collectively explained 58.4% of the variance in the model (Tschannen, Kalisch, & Lee, 2010). Likewise, missed nursing care, staffing adequacy and the type of unit were found to explain 22.4% of the variance in the model testing for job satisfaction, (Kalisch, Tschannen & Lee, 2011a). These studies with nurses in 110 patient care units from 10 different hospitals suggest that missed care is a key factor in nursing satisfaction and intention to remain in practice.

2.2. Potential causes of missed nursing care

Interruptions and multitasking during care delivery is also known to impact patient outcomes. Kalisch and Aebersold (2010) studied 36 RNs on medical surgical units, a critical care unit, and a progressive care unit in two hospitals for four-hour periods of time (136 hours total) (Kalisch & Aebersold, 2010). They defined an interruption as an event initiated by another person or by an outside factor such as a call light or pager and multitasking as being involved in two or more tasks at one time. A total of 1354 interruptions, 46 hours of multitasking, and 200 errors were recorded with nurses interrupted 10 times per hour for a rate of 1 interruption every 6 minutes. Overlapping activities occurred 34% of the time.

Nurses were tracked in an observational study to assess the impact of an electronic medical record on nursing workflow (Cornell et al., 2010) and found that during a three hour period nurses spent less than four minutes on any one task. During 98 hours of observation on two medical surgical units, 77% of activities lasted 30 seconds or less, and 40% of activities lasted 10 seconds or less. These observations reflect the complex work processes that challenge nurses and the chaotic workflow patterns that characterize an environment where the potential for missed care exists.

The construct of missed nursing care provides a model for study whereby investigators can identify nursing workflow processes that contribute to missed care.

2.3. Research objectives

The study sought to describe: 1) the frequency and reasons for missed nursing care on medical, surgical, and combined medical/surgical units, and 2) the relationships among the unit types for frequency of missed nursing care.

3. Research design and methods

3.1. Design

A descriptive correlational design was used to collect data from four sites of three hospital systems. The study received approval from each participating hospital's institutional review board (IRB) and was granted a waiver of written informed consent.

3.1.1. Setting and sample

A convenience sample from 586 nurses was obtained from 18 medical, surgical, or combined medical/surgical units in the four nonacademic medical centers. Study site one was a 356 bed Magnet® recognized medical center that had seven study units. Study site two and three, also Magnet® recognized, was a two hospital system, one 278 bed hospital with five study units and a second 190 bed hospital with four study units. The fourth study site was a 130 bed hospital located in a small midwestern city with two study units.

Units classified as medical, surgical, or combined medical/surgical were eligible. Unit type definitions were from descriptions provided with the RN Satisfaction Survey from the National Database for Nursing Quality Indicators (NDNQI®) (Kansas City, KS). Medical, surgical, and combined medical/surgical often collectively known as med/surg units were purposefully chosen as the study group for two reasons: 1) Med/Surg units make up the largest number of hospital units and 2) using similar units would control of unknown extraneous variables in the work environment. To be eligible to participate, nurses had to work at least 50% at the bedside in one of the eligible unit types, and work at least a .5 full time equivalent (FTE). Floating nurses, staff development specialists, clinical nurse specialists and nurse managers were not eligible. Clinical supervisors were eligible if they worked at least 50% at the bedside.

3.2. Measures

3.2.1. Individual characteristics

Demographic characteristics included age, educational degree, and primary shift worked. To be able to capture work environment or work burden, respondents were asked the percent of time that staffing was adequate, usual number of hours worked per week, overtime hours and missed shifts in the previous three months, and number of patients assigned during last shift worked with number of admissions and discharges. Months or years of time as a nurse and time worked on the current unit were also captured. Race and gender were omitted from data collection to assure respondent anonymity as the four hospitals were located in an area where over 94% of the nurses were Caucasian and female.

3.2.2. Unit characteristics

Four variables were collected to describe unit types. These were total unit full time equivalents (tFTE), defined as the sum of all FTEs of persons within the unit budget; RN hours per patient day (RNHPPD), defined as the RN hours spent in patient care; Case Mix Index (CMI), defined as the average of the relative value assigned to a diagnosis-related group within the study unit; and skill mix, defined as proportion of nurses to the total number of unit staff members.

3.2.3. Missed nursing care

Missed nursing care elements were measured by part 1 of the MISSCARE Survey (Kalisch & Williams, 2009) that asks nurses to rate

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