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Student's Perception of Missed Care: Focus Group Results

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Abstract

Background: With the inflation of economic constraints on health care and demand to increase care quality, there is an increasing need to develop a clear understanding of what actions by health professionals are perceived as threatening quality care. Objective: To explore graduate nursing and pastoral care student's perceptions of missed care in Norway. Research design: A qualitative study was employed with the formation of six focus groups. Data was analyzed via a thematic content of the discussions. Participants and research context: Thirty-one students attending a University College in Oslo participated. Findings: Five major themes and thirty subthemes were identified. Major themes included labor constraints, organizational contraints, professional constraints, communication constaints and emotional strain. Discussion: Findings of this study resonate with other research as well as with studies on missed nursing care. Findings also lend support to the definition of missed nursing care actions as required care that is omitted, either in part or whole, or delayed. Conclusion: The findings from this study extend understanding of what barriers health professionals perceive as inhibiting them from offering quality care. The focus groups provided a valuable flora for discussion regarding what participants perceived as missed.

Keywords

Missed Nursing Care, Suboptimal Care, Noncaring, Focus g Groups, Nursing, Pastoral Counseling

1. Introduction

Society is in a process of constant change in which the past couple of decades have seen unprecedented levels of structural health care reforms in pursuit of efficiency, effectiveness and wider access in most developed nations [1]. As a result, health care providers, administrators, and politicians face competing challenges to con-

trol expenditure, reduce clinical errors, and improve quality of care [2] [3]. Along with health service's new organizational structures, payment systems and performance requirements, the development in medical, technological and political spheres are continuously confronting with new ethical issues. For example, health care services are provided to clients in an environment with complex interactions among many factors such as the disease process itself, clinicians, policies, procedures and resources [4]. In the Western world, today's work environments are further complicated by new medical technologies and a declining average length of hospital stay, that have led to increases in the amount of care required by patients. Patients that traditionally would have been cared for in critical care environments are increasingly located on general wards. This change impacts on the care sector in a number of ways. Patients who are inpatients have more complex problems and a greater number of co-morbidities and are therefore more likely to suffer physiological deterioration [5]. Procedures requiring inpatient stays are often more complex and associated with higher rates of mortality and morbidity [6]. New medical technologies also allow many less serious ill patients who previously would have received inpatient surgical care to receive care in outpatient settings. Also, patients who in the past would have continued the early stages of their recovery in institutions, today are discharged to skilled nursing facilities or to home. Due to these global developments, the need to develop a clear understanding of what actions health professionals perceive as threatening quality care remains paramount [7]. Moreover, health care professionals are increasingly voicing the need to address everyday professional and interdisciplinary tensions and systemic concerns.

1.1. Literature Review

Missed Nursing Care

Missed nursing care is a new concept which is defined as any aspect of required patient care that is omitted (either in part or whole) or delayed and is described as an error of omission. This definition of missed care seemingly has commonalities with other terms used in the literature as suboptimal care, non-caring, uncaring, near misses and futile care [8]-[13].

In exploring aspects of missed nursing care, Kalisch [14] used a qualitative approach to determine whether opportunities for nursing care were regularly overlooked and the reasons for such missed care on medical-surgical units. Using two hospitals and focus group interviews with nurses and nursing assistants, she found nine areas of regularly missed nursing care connected to ambulation, turning, feeding, patient teaching, discharge planning, emotional support, hygiene, intake and output documentation. The reasons for missed care were often related to the nurses themselves. For example, ineffective delegation, "it's not my job syndrome", habit, the amount of time involved and denial were cited as reasons for missed care which in turn had various effects on patient outcomes. This study's results demonstrated that behaviors traditionally associated with good nursing care, were often overlooked and not completed, and nurses failed to follow up on delegated

tasks and used denial as a coping mechanism to deal with missed care.

In another study, Kalisch and Lee [15] explored whether the level of nursing teamwork impacted the extent and nature of missed nursing care. A sample (n = 2216) of nursing staff members, on 50 acute care patient care units in 4 hospitals, completed the Nursing Teamwork Survey and the MISSCARE Survey. Controlling for occupation of staff members and staff characteristics (e.g., education, shift worked, experience, etc.), teamwork alone accounted for about 11% of missed nursing care. The results of this study showed that the level of nursing teamwork impacts the nature and extent of missed nursing care.

Kalisch, Landstrom and Williams [16] examined what and why nursing care is missed. A sample of 459 nurses in 3 hospitals completed the Missed Nursing Care (MISSCARE) Survey. Assessment was reported to be missed by 44% of respondents while interventions, basic care, and planning were reported to be missed by >70% of the survey respondents. Reasons for missed care were labor resources (85%), material resources (56%), and communication (38%). The results of this study lead to the conclusion that a large proportion of all hospitalized patients are being placed in jeopardy because of missed nursing care or errors of omission.

In a more recent study, Kalisch, Hyunhwa and Friese [17] explored the extent and type of nursing care missed and the reasons for missed care. The MISSCARE Survey was administered to nursing staff (n = 4086) who provided direct patient care in 10 acute care hospitals. Missed nursing care patterns, as well as reasons for missing care (labor resources, material resources, and communication), were common across all hospitals. Eight variables were significantly associated with missed care: gender, age, job title, shift worked, years of experience, absenteeism, perceived adequacy of staffing, and number of patients they cared for. When nursing staff members were female (B = 0.84, robust $S.E.$ = 0.02, $p < 0.001$), older (B = 0.03, robust $S.E.$ = 0.01, $p < 0.001$), RNs (versus NAs) (B = 0.19, robust $S.E.$ = 0.03, $p < 0.001$), working on a day shift (compared to those on night shifts, B = 0.05, robust $S.E.$ = 0.02, $p < 0.05$), or experienced more (B = 0.04, robust $S.E.$ = 0.01, $p < 0.001$), they reported more missed care. Nursing staff who missed more shifts in the past 3 months (compared to those who did not miss any shifts, B = 0.08, robust $S.E.$ = 0.02, $p < 0.001$), perceived their staffing less adequate (B = 0.11, robust $S.E.$ = 0.01, $p < 0.001$), or cared for more patients in the previous shift (B = 0.01, robust $S.E.$ = 0.00, $p < 0.05$), reported significantly more missed care.

Quirke, Coombs and Mceldowney [9] conducted a content analysis on what they termed "suboptimal care" among acutely unwell patients. Delays in diagnosis, treatment or referral, poor assessment and inadequate or inappropriate patient management was found to be related to patient complexity, healthcare workforce, organization and education factors [18]. These authors stated that suboptimal care may have catastrophic consequences for patients such as death, intensive care admission or cardiac arrests.

Miller [19] examined variables that sustained good work among nurses despite the obstacles they encountered. Nurses cited obstacles to good work in nursing as frustration in dealing with market forces which included the growing emphasis on productivity and managed care. Strategies used to overcome ob-

stacles included prioritization, team building, contemplative practices and reflection on the initial reasons for entering the profession.

Atree [20] explored patients' and relatives' perceptions of care and identified key criteria used to evaluate quality care, via descriptions of actual care experiences among 34 acute medical patients and 7 relatives. Care described as 'not so good' were routine, unrelated to need and delivered in an impersonal manner, by distant staff who did not know or involve patients. The nature of the care provided and interpersonal aspects of caring emerged as key quality issues for patients. Lastly, in a Norwegian study, Prang, and Jelsness-Jørgensen [21] explored barriers to incident reporting in nursing homes. Thematic analysis of 13 semi-structured interviews with nurses revealed that unclear outcomes, lack of support and culture, fear of conflicts, unclear routines, technological knowledge and confidence and time and degree of severity were the main drivers of not reporting incidents.

One can summarize from these studies that missed nursing care is related to a complex variety of factors which are related to organizational structures, time, healthcare workforce, professional, material, educational and personal characteristics. What remains clear is that most authors agree that missed nursing care or suboptimal care is either avoidable or preventable [8].

1.2. Purpose

Because it has been reported that attempts to understand students' perspectives on what they perceive as missing care are seldom presented [7] [14], the aim of this qualitative descriptive study was to explore graduate nursing and pastoral care student's perceptions of missed care in Norway.

2. Method

2.1. Design

The study uses an exploratory qualitative design, in which qualitative data are collected, based on real-life experiences brought forth in focus group discussions. Focus groups were selected for enhancing the dynamics of discussions and ensuring that different perspectives would be expressed. The interactions and dynamics among focus groups members can generate important information in a data collection situation [18].

2.2. Focus Group Protocol and Participants

Purposeful sampling included students in post bachelor in cancer nursing, nephrology nursing, pastoral counselling, public health nursing, and Masters' students in community health nursing attending a university college in southeast Norway. Participants were recruited by the researcher (MK) who visited classes at this institution and explained the purpose and procedure of the study at the beginning of their classroom lectures. Six focus groups were conducted and included the following: pastoral students ($n = 4$), two groups of nephrology students ($n = 4$, $n = 5$), a combined group of public health nurses and pastoral students ($n = 8$), and two groups of cancer students ($n = 4$, $n = 6$). Focus groups were conducted in a quiet

room at the same university during April 2016-December 2016. Students were welcomed upon arrival and refreshments were served. The time span of the focus group sessions were between 40 minutes to one hour in length. Two researchers served as moderators where one led the questioning and the other observed verbal and non-verbal interaction. The first part of each session was used to provide ground rule information, remind participants about ethical considerations, and obtain written informed consent and sociodemographic information. Oral consent was also given to tape record the sessions. A short list of standardized questions and prompts were formulated in advance to move the open discussion which included meaning given to professional care. Aspects related to good caring have been published recently [18]. As the focus of this paper is on aspects of missing care, open-ended questions for this theme included: "When you think of the concept of missing care, non-caring, or the opposite of what you envision as good care, what do you think about? Can you give some examples?" "What factors do you believe contribute to not being able to give good care? Can you give some examples?" At the closure of the focus groups, the moderator summarized the main points of the discussion, to verify the accuracy of the information discussed. At this time, participants were also asked to add other comments if needed, as well as express their views regarding the discussion. Field notes were written immediately after each focus group to document impressions, themes, and group interactions. None of the students recruited from classes decided to withdraw from the study after agreeing to participate [18].

2.3. Ethical Considerations

The study was approved by the research committee at the institution where the study took place. Participation was voluntary. Students were told that their refusal to take part in the study would have no consequences for their studies. Written consent to take part in the study was obtained and oral consent was given at the beginning of the focus groups to tape record the sessions and use the results in publications. An agreement was made that the tape recorder would be turned off during parts of the dialogue, if desired. Participants also received the email address and phone number of the researcher (MK) in case there was a need for contact [18].

2.4. Data Analysis

Audio recorded interviews were transcribed in full by a professional transcriber and then translated into English by the researcher (MK). After all the six interviews were conducted, the analyses started with reading the transcribed interviews simultaneously in order to get a feeling of the whole. This holistic approach was taken in order to discern an overall and fundamental meaning of the experiences. Each interview was then condensed by highlighting passages of importance to the investigated phenomenon; by the first author (MK). This started a process of reflection and search for meaning in the text by extracting essential themes. Van Manen (1997) calls thematic analyses [22]. In this analytic

step, a list of preliminary themes was constructed, by highlighting phrases and quotes that seemed to be thematically related to professional caring. This step continued with refection over the themes by viewing them in light of each interview and the issues of interest as related to the open ended questions. In the process, the preliminary themes were constructed inductively into a hierarchy so that categories were grouped into sub-themes and themes into essential themes. A second researcher then reviewed all steps in this process, also searching for evidence that contradicts and well as conformed to this process [23]. Afterwards, critical discussion ensued until both researchers were in agreement regarding major themes, subthemes and exemplars. This procedure was an interpretative creative process and findings evolved as a result of an intuitive and reflective writing process. This process can be understood as a circular process occurring between reading and re-reading the transcribed interviews, viewing the themes in their own context, and writing and re-writing towards a higher level of abstraction. At the end of this process, the themes were supported by quotations from the interviews to enhance credibility. To enhance the validity of the categorizing method and to guard against bias, a list of themes, subthemes and quotations were then presented to a research group at the institution where the study took place. These colleagues were invited to discuss the naming and classification of the themes and sub-themes, searching for confirmation as well as contradictions to enhance the reliability of the findings [18].

3. Results

3.1. Sociodemographics

Of the 32 students, the majority were women with only 2 men participating. A large proportion were middle aged (40 - 60 years) ($n = 26$, 83.8%) and had worked up to 15 years ($n = 11$, 35.4%) as compared to those working more than 15 years ($n = 4$, 12.9%). Students working full time ($n = 16$, 51%) were approximately as many of those working half time ($n = 15$, 48.3%) and the majority were married with children ($n = 22$, 70.9%). All students were post-graduate students with a minimum of four years university education. Refer to Table 1 [18].

3.2. Qualitative Findings

Findings revealed that missed care could be categorized into five main themes and thirty sub-themes. The major themes were: 1) labor constraints; 2) organizational constraints; 3) professional constraints; 4) communication constraints; and 5) emotional strain. An overview is presented in Table 2.

3.2.1. Labor Constraints

A major theme that consistently emerged throughout the focus groups were factors related to *labor constraints*. This included workloads which featured time restraints, being too busy and not being able to carry out one's duties in a good way as shown by the following comments: "It is tiring to have so much to do and not being able to carry out your tasks in a good way which gives the patient a

Table 1. Sociodemographic characteristics of the focus groups.

Variable	Number
Number of participants	31
Gender*	
Women	29
Men	2
Age*	
20 - 30	
>30 - 40	4
>40 - 50	7
>50 - 60	10
>60	9
Marital Status*	
Unmarried	0
Married	3
Living together	19
Divorced/separated	6
Widowed	1
Educational Background	
Nursing	27
Counselling	3
Years Working*	
1 - 5	2
>5 - 10	6
>10 - 15	3
>15	4
Working	
Full time	16
Half time	15
Other	1
Children*	
Yes	22
No	4

*Missing answers.

sense of worth. Sometimes, I think to myself, would I have done this if I was a family member? It is especially difficult with senile and nervous clients." Some participants stated that they knew if they could take more time with specific clients this would be helpful, but due to limited time they were forced to perform acts that they knew were against the client's best interest as the following comment portrays: "When working night shift and I have a nervous patients, I know if I could just take the time to sit with them, this would have helped, but instead I just say, I know you are nervous, but you need to sleep. I offer medication instead." In some cases, such acts were against ethical standards as illustrated by

Table 2. Major themes and sub-themes found in focus groups regarding missed care.

Labor Constraints
Workload
Inadequate staffing
Time
Difficult patients
Withdrawal
Technology

Organizational Constraints
Leadership qualities
Time allotment
Rigid system
Lack of caring philosophy and standards
Lack of coordination
Lack of opportunities for self-reflection

Professional Constraints
Professional attitudes
Self-awareness
Personality characteristics
Not genuinely present
Judgmental
Cultural insensitivity
Relationship with colleagues

Communication Constraints
Not acknowledging
Not listening
Not asking questions
Self-interest
Not advocating
Labeling

Emotional Strain
Powerlessness
Loss of professional identity
Fatigue
Self-protective behavior
Irritability

the following: "In the evenings there are so many patients you don't have time. Instead, I set their medications on their night stands, for them to take themselves, which we aren't really allowed to do." Many discussed the aspect of time which was connected to inadequate staffing and moral distress as exemplified by the following: "You go home feeling you haven't done a good job because there were so few staff. You have had to give priority to other things when you know that the patient needed other things. For example, in the nursing home, it can almost go three years between the times patients are out in the fresh air, because of staff shortage." Other factors connected to labor constraints which were voiced included complaining colleagues, having too many new clients and the use of technology as illustrated by the following: "There is so much complaining from colleagues, this destroys a lot because we are so busy. We also get too many new patients, and then there is the new data program on top of this. All this

takes our focus away from the patients." Encounters with "difficult clients" was another factor discussed by many. Such clients were described as those who required more care than others. This resulted in having to set priorities and creating difficult feelings as illustrated by the following: "Non-caring is related to difficult patients who need more than others, which we are not comfortable with, and we think to ourselves is she ringing again?" Another stated: "Some patient's require a lot of care and this results in less care for others, especially the quiet ones who say little and make little noise." Others described how these encounters were related to distancing oneself from clients as illustrated by the following statement: "There are difficult clients where you try to create a good relationship and everything is always wrong. They bring up something you have said earlier again and again and accuse you of having labeled them in some way. They are so difficult to work with, I just have to withdraw from them and take deep breaths." For others, asking colleagues for help when working with difficult clients was a better strategy as verbalized by one: "There are some patients who can be very provocative and I need to signal to my colleagues that I need a break. There are just some patients you don't share good chemistry with." Some participants also discussed how technology was related to their workload in relation to calculating time allotted for carrying out specific caring activities. Such strict time allotment resulted in not having time to acknowledge the uniqueness of the other and reduced time for assessing and observing needs as shown by the following comments: "In community nursing we have a technical device that allots how much time we can take with each patient and tells us what our duties are. We do it and don't observe anything else." Other issues related to technology were connected to overtreatment and loss of worth as exemplified by the following statement: "For some patients we just try to delay their dying, they are over treated. They just lie on their machines which continue to peep and this isn't a worthy death. There is so much noise from the machines, no calmness and the patient doesn't feel of worth."

3.2.2. Organizational Constraints

Various *organizational constraints* were considered by the majority of participants as creating barriers for good care. This included issues related to leadership qualities. Some described bad leadership as being related to the leader's need to be liked by staff. One participant stated: "Bad leadership contributes to bad caring in that the leader wants to be friends with everyone. It is the working environment that allows this to happen. It is almost like the staff is more important than the patients." Poor leadership was also discussed in relation to unethical behaviors which had the possibility to inflict harm as illustrated by the following comments: We had staphylococcus on our floor, and our leader said, "No, this isn't so dangerous, we can't use time on developing interventions for this because it would cost too much, even if this patient is affected with this." Another verbalized: "When we write reports of nursing errors, they don't get very far in the system, they only land on the leader's desk." Time allotted by ad-

ministrative leaders to carry out activities was seen as a major hinder to good care as described by one participant: "I think, as nurses we have to learn new programs, new methods, new techniques all the time. It is almost like our leaders don't expect us to care. We are only required to use our Ipod where we punch in and out, so our leaders can see how much time we have used with our clients. If you happen to use more time than was allotted, you are called on the carpet to find out why. In the end, you have to convince yourself and accept that you can't give the little extra's. In any case, you don't ask the patient how they are feeling because it doesn't go up in the calculations. Instead, you say to your client's, 'here everything is going okay, yes?' It's all about politics and economy." Another participant stated: "In community health, administrators have calculated how much time it takes to put medicine in boxes. There just aren't any minutes calculated to give good care. The word care is out of the system now." A rigid system and lack of a caring philosophy were also described as constraints as shown by these comments: "The system is so rigid, it is difficult to give the little extra to the patients" and "Some institutions have not formulated a caring philosophy, standards or goals for care at all." Lack of coordination, postponement of referrals, not feeling cared for by the system and lack of holistic planning were also discussed. As one participant expressed: "Where I work you can see those who do their job and others who simply postpone things. I have experienced people who have to wait many, many days to come to a dentist when they have extreme pain, because the leader feels a dentist is not necessary or messages get lost in the system. The system gives the person so little worth." Others stated: "Many clients feel we don't have enough time, so they voice only their practical needs and not what they are really concerned about" and "Inter-professional care is missing, and the person isn't followed up. A client gets one treatment from one, and another treatment from another, which lacks any form of holistic planning, because each individual is intervening from their own perspective." Another stated: "Bad care occurs when we as professional are not cared for ourselves by the system. We need space and room to reflect and share."

3.2.3. Professional Constraints

Issues related to *professional constraints* were discussed by many participants. A prevalent issue included professional attitudes such as having ambitions which the client didn't share, not creating opportunities for client decision making, or feeling uncomfortable when advice was not followed as illustrated by following comments: "We can have ambitions for others which they do not have for themselves. Thinking we are right the whole time is a barrier, and this occurs quickly and often." Another theme was related to issues of self-awareness as shown by the following: "It is important not to think, I am here now and I will take care of you, and I completely take over and don't allow the other to participate in making their own decisions" and "It is difficult with those clients who don't follow our advice and make decisions based on their own beliefs. This makes uncomfortable and insecure." Another stated: "We all have our own histories, it is important that that we have reflected over our own weak points and if

one meets the same weaknesses in another, it is important to remember that the other is the most important one."

Personality characteristics were also discussed by many participants. Issues related to lack of respect and moral sensitivity were also voiced: "I have worked with many people in various institutions and bad care is not only related to staffing, but also to the personalities of those working there." Others stated: "There are so many things that hang together but some staff simply lack moral sensitivity" and "I had a patient who had just died and I was together with another nurse performing post mortem care. She just talked and talked and talked and of such silly things. I felt so uncomfortable, there was no respect from her side." Moral insensitivity was also discussed in relation to choice as the following comments illustrate: "Bad care is related to 'avoidance sins' as I call them. One simply chooses not to see nor listen to the patient, and one chooses not give good care." Other's voiced: "Some people just can't give good care. For example, I heard a nurse once say to a dying patient, it's not so dangerous to take more pain medication because you are going to die anyway" and "Bad care is not showing respect for the patient and not doing what you know you ought to do, not doing your job thoroughly." Many participants discussed not being genuinely present as another feature related to professional constraints. "Missing care is not acknowledging the patient's needs. Just taking a bit more time is the difference between good and bad care. Being genuinely present. There are so many people who aren't seen or heard or invited to take part in their own decisions." Also, factors related to being judgmental were also discussed as illustrated by the following: "I had a nursing model in practice who had such a negative stance towards my patient from the first second she walked through the door. The patient was silent and she was bathed and clothed by her, but this was done in such a hard way. There just wasn't any understanding. Afterwards, I tried to talk to her about this and she just said; "I am sorry but I have this patient up my throat, we just don't have a good relationship together." Issues related to cultural sensitivity were also expressed: "I think we have destroyed a lot with our views of cultural integration, with our kindness attitude, with the idea that we must tolerate everything. We also need to make demands. There is a lot of racism from the other side also" and "I pressed and encouraged a father from another culture to hold his premature daughter, he finally did and I felt that I had supported good caring. Instead, his wife came in and screamed at me and said that her husband felt traumatized having to hold the child. Perhaps this was good care for the baby but not for the father." Another issue related to professional constraints concerned relationships with colleagues as shown by the following: "There are too many stressed staff, they don't have control over their own lives. They walk fast, speak fast and it is the patient who suffers. One can observe one's own colleagues as not being especially caring. However, I don't think it is necessary to go directly to your leader about this. I mean that it is important to discuss what you are observing with your colleague and ask what is happening." Another stated: "I feel especially for those who are alone and have

mental problems. But I feel some nurses are only concerned with being rigid, setting boundaries and no one seems to have the capacity to listen to their histories." Some participants also discussed the need to ask colleagues for help as well. "When caring, one can experience difficult situations and sometimes we just avoid the patient. We need to be more competent in collaborating with each other and asking for help. We need to try to help each other give care instead of trying to forget or say, "I just can't cope with this" and simply withdrawing."

3.2.4. Communication Constraints

A major theme that consistently emerged were factors related to *communication*. Such factors included not acknowledging the client as a person by not listening and not asking questions as shown by the following statements: "Working in a health station, I have a checklist of so many things I have to ask about, that I concentrate on asking only these questions, and I don't see the person in front of me." Another proclaimed: "Suboptimal care is not listening to what the patient is trying to say, it is when you speak over their heads, and you drive them in the corner with your own thoughts." Other participants described restricting communication by not creating openings for dialogue as illustrated by the following: "It is bad care asking people how they are when you don't have time to listen to what they say. It's better just not to ask." Another participant stated: "My role model in practice says they do not ask the big questions because they don't have time to meet these problems." For some participants, not taking time to listen was also described as being connected to one's own self-interests as exemplified by the following: "I think about those that can't listen to their clients. They just talk and talk about what they are interested in themselves. We don't create the openings so the other can really talk about their own concerns." Other communication issues included not voicing one's own beliefs and advocating on the patient's behalf as illustrated by the following: "Bad care is when we don't take the initiative and dare say our own meanings to the doctors' regarding our patients. After all, it is we who know the patient best. This is wrong." Another communication issue was related to labeling clients which was stigmatizing. As illustrated by these comments: "I work with colleagues who label patients and say, this patient is like this and this, and what has happened is his own fault. This has happened because he hasn't tried to take care of himself" and "Language has power, big power. I work with women who are prostitutes. Why should they be labeled prostitutes? They are women and working with what they do because of necessity." Another participant described how she herself felt stigmatized: "I had a patient who needed to be more physically active and she told me I was torturing her. Nothing was ever good enough for her and so it is difficult to care because you have only two hands and must plan."

3.2.5. Emotional Strain

Lastly, many participants also described feelings related to *emotional strain* such as feelings of powerlessness and loss of professional identity. The following comments illustrate these points: "I feel like an industry worker. Also, you con-

nect your patients' to the machines and disconnect them and you don't even have time to talk with them. It's a bad feeling having to go home knowing that you have done only what you had to give priority to" and "I feel that we are just the doctors extended hand. We take blood tests, wash beds, accompany doctors on rounds, make sure they sign their orders, attend meetings, are secretaries, kitchen help, and safety guards. There is very little nursing. I am tired of it." Others described fatigue as connected to self-protective behaviors like avoidance. "One can simply get tired of people generally, you meet so many different people, children and families in just a short span of time. You have kind of reached your own limit." Others stated: "It is important to meet people where they are, but some days you are just too tired, you just say" "do this and this and this and then come back. It is almost a survival strategy so you can keep holding on. You need to protect yourself because you can go over the edge and end up burned." As described by another: "We had a physical therapist who came for consultation at school a couple hours a week. I asked her if she could put a message on her door when she would be available. She said no, because too many people would seek help." However, various participants also observed tiredness as a form of apathy observed in their colleagues as shown by the following: "I think some of the colleagues I work together with have worked too long, they are older and are apathetic but they don't see this themselves. This isn't good for the patients or for themselves." Some participants also described feelings of irritability with colleagues and viewing colleagues as meeting their own needs as shown by the following: "Some days you work together with a colleague you don't share good energy with and both of you end up complaining and blaming each other." Another stated: "I feel sometimes that my colleagues are trying to meet their own needs disguised in professionalism. I work in a prison and I think sometimes the interventions are based on their own interests like hikes in the mountains and rafting with inmates. For example, there are many existential issues which aren't met at all."

4. Discussion

In this study different understandings of the meanings given to missing care were expressed by postgraduate nursing and pastoral students. Five themes and thirty sub-themes emerged from the focus group discussions. The major themes included labor constraints, organizational constraints, professional constraints, communicative constraints and emotional strain.

4.1. Labor Constraints

Many of the descriptions confirmed experiences impacted by workloads, inadequate staffing and limited time as reported by others [16] [17]. Research by Peter and O'Brien [24] found that nurses experienced their work environments as morally uninhabitable with their social positioning leaving them vulnerable to being overburdened by, and uncertain of their responsibilities, as found in the present study. It is well known that client complexity requires a skilled health-

care force with sufficient numbers to deliver the care required together with organizational processes which support timely and appropriate care. Importantly, the negative impact of nurse-patient ratio's hinders health professionals' application of knowledge and skills [25] and is connected with detrimental outcomes [8] [17] [26]. Due to staff shortage, many participants described having to make priorities which affected the care of other patients. Prioritization of which clients to attend to first is an issue which is especially relevant when communication of the client's condition does not convey the urgency required. Moreover, when staffing is minimal this may also result in a delay or absence of communication with other team members [15].

Many participants described not having time to be genuinely present in the situation which was also related to not acknowledging the client as a unique individual and not assessing specific needs. These findings are especially noteworthy. Poor assessment, inadequate exploration, delays in diagnosis, treatment and referral, and lack of recognition of the importance of deterioration have been shown to have detrimental consequences for clients and their families [27]. Further, encounters with difficult clients were described as a major issue by many. Difficult patients have been characterized as those whom health professionals perceive as consuming greater periods of time than their condition suggests. They are described as impeding the work of staff with demands, complaints and lack of cooperation also causing self-doubt among professionals [28]. Difficult patients themselves have also been reported to experience stigmatization and receive inadequate care due to avoidance strategies by health professionals [29] [30] [31] as voiced in the present study. Participants also described feelings of frustration, anger, helplessness when encountering difficult clients, as well as labeling clients in such situations. Similar findings have been reported by others [32]. [28] explored strategies used by 234 clinical nurse specialists when caring for patients involved in "difficult" clinician situations. Unfortunately, the least frequent strategies included changing the nursing staff's assignment to the patient/family, and conducting in-service programs that address behaviors that stigmatize patients. Notably, due to limited time and workloads, some participants even expressed how they felt forced to break standards. For example, they described how they left medications on night stands for patients to administer themselves, even though they knew this was wrong. Importantly, administration errors have been found to be the result of human factors such as fatigue, stress and understaffing [33]. Medication errors have also be shown to be caused by system factors such as leadership, maldistribution of resources, poor organizational climate and lack of standardized operating procedures [34]. Leaving medications on nightstands could have been related to these factors.

4.2. Professional Constraints

Much empirical work report health professional's insensitivity to patients' needs which was also described in the present study. Such insensitivity was grounded in professional attitudes, such as not being genuinely present, lack of self-

awareness, and personality characteristics as found by others [35] [36]. Such insensitivity can be interpreted as threatening the client's sense of dignity. Jacobsen conducted a literature review and found that dignity violations in health care occur through the process of rudeness, indifference, dismissal, disregard, dependence restriction, discrimination, deprivation, assault and objection [37]. Avoidance tendencies, as a form of dismissal, and discrimination in the form of labeling clients, together with various forms of disregard were also found in the present study. In another study, Thorsteinsson [38] explored patient perceptions of bad quality care. Characteristics of nurses included those who were also indifferent, took no initiative, and had a negative attitude. Altree [20] also found "not so good" care was described as being routine, unrelated to need and delivered in an impersonal manner, by distant staff who did not know involve patients. These studies correspond with present findings. Importantly, in a recent landmark report in the United Kingdom, Darbyshire and Mckenna [39] found that nurses couldn't care less about the erosion of caring and compassion in nursing. Such findings are extremely important in considering the outcomes of poor quality care.

Various participants also described how their care was related to teamwork and relationships with colleagues as shown in the study by Kalisch and Lee [15]. In the absence of an effective team work culture, others have found that a higher number of problems related to suboptimal care occur [40]. Shift work and staff shortages have also be shown to have detrimental effects on team work as described by many participants [41]. Moreover, lack of professional trust among colleagues has been shown to lead to a lack of clarity of professional roles, lack of team support and professional hierarchies. For instance, when professional hierarchies exist, junior staff were found to be reluctant to call for help when experiencing difficulty for the fear of losing face [9]. In the present study, junior participants working with role models also discussed difficult feelings. Fear of conflicts were also expressed in the Norwegian nursing home study [21]. Thomas, Sexton and Helmreich [42] measured and compared critical care physician's and nurses' attitudes about teamwork ($n = 230$) in eight nonsurgical intensive care units. Only 33% of nurses rated the quality of collaboration and communication with the physicians as high or very high. Nurses reported that it was difficult to speak up as affirmed in our findings. The authors concluded that physicians and nurses have discrepant attitudes about the teamwork which includes suboptimal conflict resolution and interpersonal communication skills. In another study, Johnson [43] described the results of a survey among 33% doctors and 67% nurses in the United Kingdom. Behavior problems were found to be very pervasive where nearly 89% of the respondent's reported witnessing behavior problems between doctors and nurses. A surprising 10 percent said they witnessed problems between doctors and nurses every day.

Various participant's voiced how negative role behavior impacted their care. This was related to behavior observed in colleagues, leaders, and student role models. The influence of role models on student's caring behaviors is well do-

cumented. For example, Fang and colleagues [44] explored baccalaureate nursing student's perspective on learning about caring in Chinese focus groups. Results demonstrated four themes which included learning by positive role models as an ideal way of learning, negative role models as another way of learning, lack of directive substance as a hindrance to learning care, and lack of cultural competence as a barrier to learning about caring also supported by present findings. Traynor and Buus [45] explored professional identity among 49 second and third under graduate students in six focus groups in the United Kingdom. Student's described qualified nurses as either possessing caring characteristics or having "lost" it as described in the present study. In this study participants described strategies for not becoming corrupted in professional practice which included distancing from "bad" qualified nurses. Notably, Byszewski and colleagues [46] reported that over time, behavior that students previously considered unprofessional, became increasingly more acceptable as students progressed in their training, indicating some erosion of values. Also, in a systematic review and meta-analysis of qualitative literature concerning the experiences of British student nurses in hospital settings, Thomas, Jack and Jinks [47] uncovered negative clinical experiences which endured through time. Such findings raise concern regarding the long term effects of negative experiences. Other professional constraints included a lack of cultural competency while others expressed cultural insensitivity. This is important considering other studies involving students have also reported observations where nurses appear reluctant to provide care to ethnic minorities [48] [49] and where a lack of cultural competence creates barriers to learning about caring [44] as found in our findings.

4.3. Organizational Qualities

The majority of participants described ways in which leadership qualities and organizational obstacles influenced their caring encounters. Findings seem to confirm an air of dehumanization, fragmentation and focus on doing more "faster" with unsustainable staffing and excessive demands on fewer practicing. This growing emphasis on productivity was also cited in Miller's research [19]. This was compounded by having to follow technical apparatus which plotted how much time was allowed per client and per task. Values seemed to reside in the efficient, economical and the procedural where obligation and commitment to clients could be seen at odds with organizational demands. Creating a positive culture in which health professionals can flourish has been described as the responsibility of leaders who should model behaviors that support good caring [50]. Conversely, some of the participants attributed missing care to destructive leadership tendencies. Destructive leadership has been defined as the systematic and repeated behavior by leaders that violates the interest of the organization by undermining and/or sabotaging the organization's goals, tasks, resources and effectiveness and/or the motivation, well-being or job satisfaction of the employee [51]. Participants described rigid systems with lack of coordination, postponement of referral's, staff not feeling cared for by the system and lack of

holistic planning. Concern with establishing camaraderie with staff was also described. Destructive leadership behavior may not be intended to cause harm, but as a result of insensitivity or lack of competence it undermines staff and the organization often at the cost of the staff.

Participants also discussed a lack of caring philosophies and standards absent in organizational structures. Healthcare organizations must critically examine the absence and presence of professional values and whether incongruence between what is espoused, and what is done, propagates less ethical actions. This also includes leaders being consciously aware of how their own ethical standards and actions, influence staff and client outcomes, such as not stopping staphylococcus outbreaks and not acting upon reports of poor quality care as pointed out in in this study. A major task of administrative leaders at all levels is handling complaints of unethical and disruptive behavior and dealing with it immediately. Health care organizations and facilities also need to have codes of conduct defining acceptable and nonacceptable caring behaviors, establishing a process for managing unacceptable behaviors and enforcing codes of conduct even under economical contraints.

Tadd and Read [52] also pointed out that failure to provide dignified care often resulted from systematic and organizational factors as confirmed in our study. At the same time, nurses must deal with organizational constraints alongside moral distress as confirmed by our findings. Moral distress is defined as painful feelings and/or the psychological disequilibrium that occurs when health professionals are conscious of the morally appropriate action a situation requires, but cannot carry out the action, because of institutional obstacles. Many participants seemingly knew what the right thing was to do, or what they felt they should do, or ought to do, in their caring encounters. However, due to workload, inadequate staffing and time allotment they were unable to do what they knew was best for their clients. Many discussed how this created difficult feelings. Such findings have been found by others. In a survey by the Royal College of Nursing [53] where over 2000 UK nurses participated, results showed that 70% of the nurses sometimes left work feeling distressed and 11% always left work feeling distressed, because they couldn't deliver the kind of dignifying care they knew they should provide.

4.4. Communication Constraints

Observational studies have found that dignity may also be influenced by health professionals communicative style as supported by our study [54]. Clear communication has been especially highlighted as important in preventing suboptimal care [55]. Issues related to communication such as not acknowledging clients, not listening, not asking questions, self-focus, not advocating on the client's behalf and labeling clients were discussed by many. Communication is not just about what a person says, but how he or she says it. Effective communication is critical during the countless interactions that occur among health professionals on a daily basis. When effective communication is absent, client care is

compromised. Furthermore, hierarchy differences, conflicting roles, ambiguity in responsibilities and power struggles have also been shown to lead to communication failures that compromise patient safety and quality of care.

Notably, rude language and hostile behaviors were voiced by some participants. Such behaviors are reported to foster medical errors, contribute to poor patient satisfaction and adverse outcomes [56]. Importantly, such intimidating behavior has been found to be such a serious problem that a Joint Commission in the USA issued a Sentinel Event Alert urging organizations to take specific steps to curb this problem. The Joint Commission [57] has also introduced a new standard requiring accredited organizations to create a code of conduct that defines acceptable and unacceptable behaviors and to establish a formal process for managing unacceptable behavior. Improving communication strategies such as these, requires a systems approach, including creating a culture that emphasizes open communication as a crucial component of safe quality care. It has also been shown that using needs assessment and systematic tools for determining goals, identifying discrepancies between optimal and actual performance, and establishing priorities for action can assist organizations to improve communication [58].

4.5. Emotional Strain

Feelings of emotional strain were discussed by the majority of participants. Feelings of powerlessness, loss of professional identity, fatigue, irritability and the need for self-protective behavior were themes often voiced. Others have reported how nurses report dissatisfaction and low morale as they cope with time constraints and staffing shortages which were also discussed by participants. For example, Cummings and colleagues [59] point out that dissatisfaction among nurses is often related to concern over unattended patient care needs, emotional strain and disruption in workgroup collaboration as found in our study. Turkel [60] found that consequences of non-caring experiences includes lack of control, despair, helplessness, vulnerability and being alone. Thorsteinsson [38] also described poor quality nursing care as producing negative feelings such as anger and stress. These feelings were also described by some participants. Importantly, it has also been written that health professionals own distress poses a threat to caregiver's perceptual accuracy of patient experiences [61]. Similarly, it has been shown that when caring behaviors are not visible or when patient needs are not met, patient satisfaction is compromised [62]. Importantly, emotional strain is strongly associated with self-awareness [63]. Many participants expressed the need for the creation of opportunities for self-reflection and dialogue to counteract difficult feelings and reactions. This importance of a supportive environment to reflect, understand and discuss emotional strain is vital in caring has been affirmed by others [64].

In sum, findings of this study resonate well with other research as well as with studies on missed nursing care [14] [15] [16] [17] [18] lending support to the definition of missing care actions as required care that is omitted, either in part

or whole, or delayed in action [13]. One can also question whether some of the missing actions can be regarded as examples of unethical behavior? Healthcare professionals working in clinical practice, administration, education and research are not immune to unethical behaviors. They face ethical dilemmas on a regular basis as evidenced in this study. Notably, shortages in the numbers of professionals to deliver patient care, inadequate staffing levels, cost containment measures, and ineffective leadership have resulted in the escalation of ethical dilemmas faced today in healthcare environments [51] [65] [66] as evidenced in our results.

5. Limitations

The study is limited because of convenience sampling and a small sample consisting of a majority of women, although their age spans differed greatly, limiting the generalizability of the findings. Furthermore, participants were recruited from only one institution although they lived and worked in many geographical areas in Norway and had backgrounds in community health nursing, cancer nursing, nephrology nursing, public health nursing and pastoral care. The probing questions captured a glimpse of the obstacles in giving care at a particular point in the professional experience of each participant. This could be a limitation reading the rapid and constant changes occurring in health systems. However, the focus groups provided a valuable flora for discussion related to what participants perceived as missed care. A relevant follow up study might be to use the same design with students from another country or countries to validate the international nature of the study issue. The names given to the major themes and sub-themes were discussed by two independent researchers, yet the selected terminology used in classifying themes and sub-themes denote specific nursing knowledge. However, interpretations of the themes and sub-themes were reviewed by inviting colleagues with different expertise and backgrounds to review the results. The moderators had previous experience with conducting focus groups. The moderators played a more passive role, using probes when needed, but allowing discussion to evolve openly. Because all of the groups had been recruited in their own classrooms, the atmosphere of the groups portrayed a sense of group membership and cohesiveness. Notably, research has shown that there is a tendency for more self-confident and articulate individuals to be more willing to agree to take part in focus groups. In two of the groups, certain members were more assertive and as a result the more silent participants had to be invited into the dialogue. Also, in groups where there were a majority of older participants, the younger tended to be less articulate. Tape recording the sessions, could have caused feelings of unease for some, and one group commented that it would have been easier to speak together without the tape recorder. However, in all groups participants were able to narrate their experiences and perceptions of what they considered was suboptimal care and the focus groups created a space which was filled with embodied dialogue. Interestingly, some of the most valuable information was discussed towards the end of the group, which could be re-

lated to the fact that the participants felt safe and were more at ease [18].

6. Future Recommendations

The environment within which professionals work, client care demands, time and staffing available to provide that care, all have an impact on patient outcomes. Based on the results of this study and other research, it is recommended that future studies explore and identify the types and reasons for care being missed in various health care settings. Future research is needed which focus on causal factors to missed care and how these factors directly influence the degree to which missing care occurs, as well as explore the specific client and nurse outcomes. Such studies could help inform quality improvement efforts in reducing regular omission of various elements of care and in securing favorable and safe patient outcomes.

Moreover, missed care also needs to be examined within a theoretical context and studied systematically in multiple cultural contexts that openly recognize it as a universal factor in client safety. Consequently, missed care is a client safety issue which would benefit from international collaborative research to enable a shared understanding of the meaning of care which is "missed." Studies based on more objective measures which capture why clients experience delayed, inadequate or inappropriate care should be developed to more clearly to help define missed nursing care. Since the consequences of missed nursing care presents threats to patient safety, it is also recommended that studies on missed nursing care should be given consideration in state and national policy development globally.

Studies are also needed which also explore professionals own perceptions of caring so that they can evaluate their nursing practices. For example, health care professionals need to reflect upon care practices that leave clients feeling depersonalized. Studies which explore the choices that health professional face when they must deal with factors in their environment, and how they reach the decisions they do in providing care to their clients, should be given priority. Studies are also needed which focus on the identification of patient's and relative's perceptions of the attributes of care quality, together with other studies which focus on how client and family perceptions coincide or differ from professional perceptions. Other recommendations also include the need to test the effect of innovative programs or clinical care pathways that address difficult professional-client situations. Furthermore, studies which explore and develop valid and reliable care quality audit indicators for the assessment and evaluation of care quality and client satisfaction are of vital importance should remain paramount.

7. Conclusion

With the inflation of economic constraints on health care, demand to increase care quality and increasing demand of client's perspectives into care, there is an increasing need to develop a clear understanding of which health professional behaviors may threaten quality care [2]. The findings from this study extend

understanding of what barriers health professionals perceive as inhibiting them from offering quality care. Participants articulated obstacles related to labor constraints, organizational constraints, professional constraints, communication and emotional strain. Many of the findings lend support to the definition of missed nursing care as being care that is omitted, either in part or whole, or delayed. These findings have implications for organizational systems, professional practice arenas, and health care education. Integration of ethical and philosophical reflection on the importance of values in healthcare programs together with principles, rules, and standards of practice that guide both unethical and ethical behavior in challenging situations needs to be openly addressed in order to prevent and reduce attitudes and behaviors related to missed nursing care.

Acknowledgements

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