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Unfinished nursing care reasons as perceived by nurses at different levels of nursing services: Findings of a qualitative study

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Abstract

Aim: This study aimed to investigate reasons for unfinished nursing care across the whole levels of the nursing service as perceived by clinical nurses, ward managers and executive nurses.

Background: Even though unfinished nursing care has been considered an issue affected by the system, no studies to date have attempted to investigate reasons across the whole levels of the nursing service by involving clinical nurses, ward managers and executive nurses.

Method: A descriptive qualitative approach was performed in 2021 according to the COnsolidated criteria for REporting Qualitative research guidelines. A large public health care trust was approached, and a purposeful sample of clinical nurses, ward managers and executive nurses was invited to attend face-to-face or online interviews. Twenty-nine interviews were performed (19 clinical nurses, 7 ward managers and 3 executive nurses) and transcribed verbatim. Then, a content analysis was conducted by considering all narratives together followed by an analytic process to identify themes and subthemes at the clinical, ward manager and executive levels.

Results: Reasons for unfinished nursing care have emerged at five levels: system (e.g., poor support towards nursing care), unit (e.g., ineffective models of nursing care delivery), nurse managers (e.g., inadequate nurse manager leadership), nurses (e.g., weaknesses in education) and patients (e.g., increased demand for patients' care).

Conclusion: The evidence available should be expanded to include also unfinished nursing care reasons identified at the system and at the ward manager levels, that both can complete the perceptions of the clinical nurses.

Implications for Nursing Management: The actors composing the nursing service perceive different reasons and therefore should be involved in detecting and contrasting the unfinished nursing care. The reasons applied or established at the upper level influence the bedside levels: Therefore, strategies to prevent or minimize the

unfinished nursing care should be designed at multi-levels in a system-inclusive approach.

KEYWORDS
antecedents, nursing service, qualitative study, reasons, unfinished nursing care

1 | BACKGROUND

The concept of unfinished nursing care, also known as task undone, missed nursing care or implicit rationing of nursing care, was developed in the early 2000s, documenting that omissions or delays in nursing care are possible (Jones et al., 2020). Since its establishment, researchers have attempted to merge the underlying unfinished nursing care anteceded by conceptually describing the reasons for and providing evidence of them with empirical studies.

At the conceptual level, task undone was the first approach developed by Sochalski (2004) and Lucero et al. (2009) as 'necessary things left undone by nurses' (Lucero et al., 2009, p. 3). In their conceptual framework, lack of time was the principal reason for task undone: However, the analysis of the causes was less important than measuring the occurrence of the phenomenon (Lucero et al., 2009; Sochalski, 2004). Later, Al-Kandari and Thomas (2009) began to reflect on factors leading to task undone, emphasizing the role of the number of patients in the unit, the nurse–patient loads, the number of unstable patients assigned to each nurse, the nursing and non-nursing tasks performed and the total workloads assigned in each shift. Around the same time, Kalisch (2006) established the missed nursing care framework, and reasons were identified as the lack of staff, the time required for each nursing intervention, the poor skills on delegation and the 'It's not my job' syndrome as the expression of certain habits. In the MISSCARE Survey, reasons were established as being labour, material resources and communication issues (Kalisch et al., 2009).

A further conceptual approach was developed by Schubert et al. (2005), with the implicit rationing of nursing care framework, where reasons were identified in the lack of resources; additionally, five influencing factors were identified as the (a) hospital-level organization, (b) nurse work environments, (c) philosophy of care, (d) nurses' characteristics and (e) patients' characteristics. More recently, the unfinished nursing care framework (Jones et al., 2019) has recognized that the phenomenon is linked to the efficient allocation of resources in a context of resource scarcity, where other elements, such as political, cultural and ideological factors, may modulate the occurrence of unfinished nursing care.

Considering empirical evidence, several studies have attempted to document factors leading to unfinished nursing care. Quantitative studies have been recently summarized in a systematic review by Chiappinotto et al. (2022), where reasons have been set at (a) the organizational levels, such as staffing and resource adequacy, poor patient-to-nurse ratio and hour per patient day, workload intensity, high non-nursing tasks, overtime and the poor quality of work environment; (b) the nurses' levels, such as the degree of absenteeism, satisfaction or personal accountability; and (c) the patients' levels, such as clinical instability that requires more care, thus leading to unfinished nursing care. Differently, qualitative studies have never been summarized to date, despite qualitative approaches have been used from the start to merge the reasons for missed nursing care (Kalisch, 2006) with focus groups. The perspectives of clinical nurses were also investigated by Harvey et al. (2018) regarding the process of care rationalization and by Rezaei-Shahsavarloo et al. (2021) merging the unfinished nursing care reasons among hospitalized frail patients. However, to the best of our knowledge, only Dehghan-Nayeri et al. (2018) as also underlined by Caldwell-Wright (2019) and Mantovan et al. (2020) involved nurse managers, working in oncology and acute care settings, respectively. Therefore, even though unfinished nursing care has been considered an issue affected by the system (Jones et al., 2019), no studies to date have attempted to investigate the reasons across the whole level of the nursing service (International Council of Nurses [ICN], 2022). Expanding the knowledge on the underlying reasons for unfinished nursing care by involving nurses appointed at different levels of the nursing service, namely, at the clinical, middle-management and executive levels, will allow a broader understanding of the phenomenon and the reasons for it, as experienced by the whole nursing system. Contributing to this expansion of knowledge was the main intent of this study.

2 | METHODS

2.1 | Study design

A descriptive qualitative approach (Sandelowski, 2010) was performed in 2021 and reported according to the COnsolidated criteria for REporting Qualitative research guidelines (Tong et al., 2007) (Table S1).

2.2 | Setting and participants

A large public health care trust of the National Health Service, located in the north-east of Italy, providing care to around 888,309 citizens (on an annual basis) with 9332 health care workers, 3868 of whom were nurses, and organized in six hospitals for a total of 2390 beds (Regione del Veneto, 2021), was approached. According to the Italian laws, three levels of nurses are appointed in the nursing service: (a) clinical nurses, educated at the university level with 3 years in

length bachelor, to ensure care responsibilities; (b) the ward managers educated at the university level with 1-year course (60 credits) as mandatory to be appointed in managerial roles and responsibilities; and (c) the executive nurses, educated at the advanced university level (Master of Science, 120 credits), with managerial responsibilities at the hospital levels.

A purposeful sample (Patton, 2015) was chosen to include nurses at different levels of the nursing service, sensitive to the phenomenon under consideration. Those eligible were (a) clinical nurses involved in the care of medical patients, as full- or part-time nurses, after at least 6 months of experience in the context, and willing to participate in the study; (b) ward managers, with at least one year of experience and willing to participate; and (c) executive nurses, with at least 1 year of experience and willing to participate. Therefore, those nurses who were only recently hired, without care or managerial responsibilities and not willing to participate were excluded.

Clinical nurses were identified by researchers and the ward managers; ward managers were identified by executive nurses, whereas the latter were identified by the hospital nurse director. They were invited to participate in the study via an email, which provided a full explanation of the aims of the study and its procedures. The recruitment ended when saturation was achieved (Morse, 1995), that is, when data have been considered completed, dominant themes were recurrent and no other themes emerged as judged independently by two researchers (S. C. and A. P.). A total of 19 clinical nurses, 7 ward managers and 3 executive nurses were involved. Nine clinical and two ward manager nurses did not reply to the email requesting participation; therefore, they were considered as refusals.

2.3 | Data collection process

An interview guide composed of open-ended questions was designed by two researchers, following the questions used by Kalisch (2006) in her focus groups, first identifying the underlying reasons for missed nursing care. Then, additional literature was consulted to refine the questions (Chiappinotto et al., 2022; Dehghan-Nayeri et al., 2018). The questions were piloted with five nurses to assess their understandability and feasibility, and the final interview guide included: (a) demographic/professional data; (b) a recall of a particular unfinished nursing care episode; and (c) which its regards, the perceived antecedents of unfinished nursing care (Table 1).

TABLE 1 Interview guide for clinical nurses, ward manager and executive nurses

Interview guide
• Presentation • Aim of the study and data collection process • Consent for interview and audio-recording
First section
• Age • Nursing education • Working profile • Experience as a nurse, in the current role and in the current setting (years)
Second section
• Recall of a particular episode of unfinished nursing care • Narration of the perceived reasons triggering the episode narrated • Other reasons of unfinished nursing care according to the personal experience • Other issues that the participant desired to be shared in the field of unfinished nursing care

After having obtained the consent to participate in the study, the interviews were scheduled between May and August 2021, according to the day/time proposed by each participant and also taking into consideration the modality preferred: face to face ($n = 3$) or online ($n = 26$).

2.4 | Data analysis

The demographic profile of participants has been summarized in frequencies, percentages, averages and standard deviation. Then, a content analysis framework (Elo & Kyngäs, 2008) was used, a systematic approach allowing a detailed description of the phenomenon to be obtained and based upon three phases: preparation, organization and reporting. In the 'preparation phase', the researcher (S. C.), who performed the interviews, transcribed the interviews verbatim. Subsequently, two researchers (S. C. and A. P.) read the text individually to gain a general understanding of the data; then, each researcher separately underlined the units of analysis as sentences or words with meaning. The 'organization phase' involved an inductive approach by performing an open coding, where labels were identified by encoding the data obtained. Then labels were grouped and assigned to a single category, according to their similarity and differences. The categories were then abstracted into subthemes and themes by formulating a general description of their contents and by providing one or more quotes for each. According to the aims of the study, the data analysis was performed across the whole level by considering all interviews; then, an analytic process was conducted by identifying the specific themes and subthemes for each level involved—clinical, ward manager and executive. An example of the coding tree is reported in Table S2.

The 'reporting phase' involved the writing of the search results according to the COnsolidated criteria for REporting Qualitative research guidelines (Table S1). Strategies used to ensure trustworthiness (Lincoln & Guba, 1985) have been summarized in Table S3.

2.5 | Ethical issues

The study was approved by the Health Care Trust Board (Azienda AULSS 2 Marca Trevigiana on March 26th, 2021). All participants freely participated, and no rewards were offered. To ensure privacy and confidentiality, interviews and quotations were anonymized by attributing a progressive number. Study findings have been provided at all levels of the nursing service involved where implications have been also discussed.

3 | RESULTS

3.1 | Participants

As reported in Table 2, participants were mainly female (27/29), with Bachelor of Nursing Science (22/29) and working full time in their position (25/29); clinical nurses were, on average, younger (35.6 years; standard deviation 9.2) compared to the ward managers (48.1; standard deviation 5.7) and executive nurses (50; standard deviation 3), with the current role of 11.2 years (standard deviation 8.5), 4.3 years (standard deviation 3.4) and 7.7 years (standard deviation 7.2), respectively.

3.2 | Reasons for unfinished nursing care

Unfinished nursing care reasons have emerged at the five levels, namely, at the system, unit, nurse managers', clinical nurses' and

TABLE 2 Demographic characteristics of nurses

ID	Gender	Age (range)[a]	Nursing education	Working profile	Experience as a nurse (years)	Experience as ward manager nurse/executive nurse (years)	Experience in current area (years)
Clinical nurses							
1	F	40–45	Nursing diploma	Full-time	19	—	3
2	F	26–30	BNS	Full-time	3	—	1.5
3	F	56–60	Nursing diploma	Full-time	33	—	2
4	M	26–30	BNS	Full-time	5	—	1.5
5	F	26–30	BNS	Full-time	5	—	1.5
6	F	30–35	BNS	Full-time	5	—	0.5
7	F	40–45	BNS	Part-time	16	—	11
8	F	26–30	BNS	Full-time	3	—	1
9	F	20–25	BNS	Full-time	3	—	1
10	F	30–35	BNS	Full-time	9	—	3
11	F	30–35	Nursing diploma	Part-time	12	—	11
12	F	30–35	BNS	Full-time	9	—	2
13	F	50–55	BNS	Full-time	10	—	4
14	F	40–45	BNS	Part-time	18	—	18
15	F	36–40	BNS	Part-time	14	—	9
16	F	46–50	Nursing diploma	Full-time	27	—	22
17	F	20–25	BNS	Full-time	3.5	—	3
18	F	30–35	BNS	Full-time	4	—	1
19	F	36–40	BNS	Full-time	15	—	14
Ward manager nurses							
1	F	46–50	BNS+[b]	Full-time	27	9	9
2	F	50–55	BNS+[b]	Full-time	34	22	2
3	F	40–45	BNS+[b]	Full-time	13	3	3
4	F	40–45	BNS+[b]	Full-time	14	3	3
5	F	40–45	BNS+[b]	Full-time	27	9.5	9.5
6	F	56–60	BNS+[b]	Full-time	40	31	2
7	F	46–50	BNS+[b]	Full-time	26	8	2
Executive nurses							
1	F	50–55	MNS	Full-time	33	15	3
2	M	46–50	MNS	Full-time	25	16	16
3	F	50–55	MNS	Full-time	31	18	4

Note: Full-time: 36 h/week; part-time: <36 h/week.

Abbreviations: BNS, Bachelor of Nursing Science; F, female; M, male; MNS, Master of Nursing Science.

[a]To ensure confidentiality.

[b]All have attended and additional university advanced course, 1 year in duration, focussed on unit coordination and management (60 credits, 1800 h).

TABLE 3 Level, themes, subthemes and levels of the nursing service

Level	Themes	Subthemes	Clinical nurses	Ward manager nurses	Executive nurses	Quotations
System level	Poor support towards nursing care	Lack of nurses and nursing care value	*			Certainly, these are settings that not provide for the centrality of the nurse and that not ensure that he/she is the fulcrum of the care project, of caring for the patient. (CN 17)
		System insensitive to the unfinished nursing care			*	One is certainly an organization that did not respond to the needs of the nurses to be supported in delivering the care required on time. (EN 1)
		Higher bureaucratization of the system	*	*	*	I mean, nurses still do a lot of administrative work. (EN 3)
		Lack of investments in electronic records	*	*	*	[…] the lack of electronic health records that can facilitate the work of nurses. (EN 1)
Unit level	Inappropriate care environment	Layout of the environment	*			That is a further waste of time, that the ward is very large, very dispersive and you have no idea where the people you need are …. (CN 5)
		High number of patients in each room	*			There were three-person rooms, therefore the rooms were even more messy. (CN 5)
		Chaotic environment	*			Medical wards are very chaotic, at least in the experience that I have. (CN 12)
	Insufficient material resources	Material resources unavailable or limited	*	*	*	Not having materials to wound care or of very simple things. (CN 17)
	Insufficient human resources	Higher nurse–patient ratio	*			But sometimes it's impossible with the time we have and the number of patients we have. In other words, there are two nurses at night for 60 patients and it's not easy. (CN 11)
		Nurses' shortages	*	*	*	Well, trivially, I am reminded of the insufficiency of nursing staff compared to what the (patients') needs are. (EN 2)
		Nursing aides' shortages	*	*	*	In acute care wards, less importance is rightly given to the provision of support staff. However, the management of mobilization, rather than the surveillance, […] I need the nursing assistants. (WMN 6)
		Physician unavailable (e.g., off the unit)	*			There are times when I may not have any medication prescribed for pain. […] So, I need to call the physician. And maybe he/she is busy with something else … because he/she obviously has other patients. (CN 9)
	Ineffective inter- and intra-professional cooperation	Poor teamwork (lack of collaboration and communication/lack of in-group reflection on action)	*	*		There is not a team, there is not a group. Also, it depends on the people, like everywhere. But there is no group, we do not feel like a group, or like a team. (CN 3)

(Continues)

TABLE 3 (Continued)

Level	Themes	Subthemes	Clinical nurses	Ward manager nurses	Executive nurses	Quotations
		Tension or communication breakdowns between • nurses and medical staff, • nurses and nursing aides, • nurses and ward managers, and • nurses and patients	*	*	*	There is no collaboration. Both between physician and nurses, and between nurses and nursing assistants. (CN 5) […] or, sincerely speaking, when you take care of a patient, as I said before, who is grumpy, you do not want to stay with him and 'waste time' with him. I mean, we are humans. (CN 11)
	Ineffective work processes	Unpredictability of the work process	*	*		Emergency-type events, a new hospitalization, rather than an urgency of a particular patient, which of course, hi/she 'steal' the nursing time, reducing the time available to do something else. (WMN 5)
		Overlapping activities	*	*		[…] that more patients call me, but I cannot divide myself. (CN 9)
		Large number of discharges and admissions	*	*		[…] even the overlapping of hospitalizations rather than discharges. (WMN 7)
		Ineffective routine	*	*		I mean things that maybe we do automatically, which take away our care time to do other things. (WMN 5)
		Lack of shared procedures	*			There are no common lines that could give us a benefit. Nurses who have been working for a long time, know well the organization and the procedures as routines. Those newly hired no. (CN 16)
		Higher frequency of interruptions	*			The phone, the phone cuts off a lot of interventions that are postpone or missed. (CN 2)
	Ineffective shift design	Weekend	*			Also, the fact that, having happened at a weekend, there was no continuous coverage from his physician, which maybe could have speeded things up a bit. (CN 1)
		Night shift	*			Then at night everything becomes a bit exacerbated, accentuated. (CN 1)
	Ineffective models of nursing care delivery	Models of care delivery: functional nursing	*		*	Even the functional nursing plays a role. It is obvious that you do not have a total view, you do not see the patient in its entirety, you do the intervention and then you move on to the next patient. (CN 10)
		Incomplete or ineffective handovers	*	*		Such as a wound care. It is obvious that if I treat the wound today, you treat it tomorrow, another colleague treats it on the third day, without an effective handover … you are unable to assess whether the wound is improving or worsening, that's it. (CN 10)

(Continues)

TABLE 3 (Continued)

Level	Themes	Subthemes	Clinical nurses	Ward manager nurses	Executive nurses	Quotations
Nurse manager level	Inadequate nurse manager's leadership		*			Even the ward manager nurses are not always adequate, maybe they are forced to be inadequate by the priorities imposed by the system. (CN 6)
Nurse level	Ineffective nurses' performances	Increased age	*	*		That our population, not of patients, but of the nurses, is aging. We are getting old again. If you have nurses starting to approach their 50s and beyond, you cannot think of them as the 20–30-year-old ones that you can ask to run to get everything done. You can ask for what is right and proper, what is necessary. (WMN 6)
		Lack of work experience, knowledge and competence	*	*		I can have more or less expert nurses in my context, so they can do a sort of analysis when a patient's needs arise and they can identify the priority. But if I have a group of new nurses, not very experienced, the fact of having so many requests could make it difficult to define priorities. (WMN 7)
		Lack of responsibility	*	*		I would not like to say indifference, because that word is bad, but not feeling the responsibilities … yes. This allows the nurse to say 'Oh well, I do not do that', which is not nice. (CN 19)
		Low motivation	*	*	*	So there is always some motivation behind it in my opinion. The low interest in the job, the low responsibility as I said before, are factors that lead to not reach the expected goals. (CN 7)
		Higher stress	*			Maybe work stress in general. The feeling of stress in general in our work. (CN 14)
		Fatigue	*			Like the tiredness of some of my colleagues. Who are tired of work and therefore maybe limit themselves. (CN 8)
		Poor time management skills	*	*		Sometimes even bad organization. Because we lost time in one intervention and then we realize that we could have given priority to something else. (CN 15)
		Ineffective delegation skills			*	Of a bad attribution of the activities to be done, because it could be given to nurse assistants who are not able, and therefore have little understanding of what the situation is. (EN 1)
	Weaknesses in education	Incomplete training or mentoring (in the transition as a newly qualified graduate)	*	*	*	[…] a lack of training, even with respect to specific nursing skills. (EN 1)

(Continues)

TABLE 3 (Continued)

Level	Themes	Subthemes	Clinical nurses	Ward manager nurses	Executive nurses	Quotations
		Inadequate orientation of new staff	*			Perhaps there is also a lack of adequate orientation of the new staff. (CN 16)
		High nursing turnover	*	*		Maybe one thing was staff turnover. We did not have the time to coach a new colleague, […] that immediately he/she went away. (CN 9)
	Poor humanistic view of patient care	Nursing care not patient-centred	*			A hospital dynamic that is less centered on the patient and more on activities, more on organizational needs than on patient's needs. (EN 2)
		Disruption of the continuity of care	*			I realize that … especially working part time, I often change sector and actually see the patient for the first day so at risk to miss important interventions. (CN 11)
	Ineffective priority-setting skills	Time required for a nursing intervention	*	*		There are many who would like to talk and you do not have the time. You also try to stay there, but they perceive your hurry, they perceive the fact that we are perpetually running. They say: 'Look, I'm not talking because I do not want to disturb you'. (CN 5)
		Higher propensity to prevent legal/medicolegal issues	*			[…] … there is often fear of legal implications, so we spend a lot of time in filling in the documentation. (CN 17)
		Wrong nursing care planning	*			Wrong decisions and priorities in the care plans mean an increased risk of missed care. (CN 2)
Patient level	Increased demand of patients' care	Patient instability	*	*		Because of the clinical instable patients, you neglect the other, more stable, already hospitalized for a couple of days. (CN 1)
		Patient complexity	*	*		Their complexity is also higher, with several interrelated issues, problems, and risks. (CN 11)
		Patients' needs	*	*		Basic needs are also increasing. (WMN 1)
		Patients' cognitive impairments	*	*		[…] patient's cognitive decline means that you can achieve less because their lack of cooperation. (CN 1)
		Patient loneliness	*	*		Patients are elderly … several have no family members with whom to relate or who acted as an intermediary. (CN 3)
	Lack of carers' support	Carer absent (e.g., off unit)	*			The fact that they (patients) do not have visits now, that they do not see their relatives, makes it worse. It gets worse. It gets much worse because they are much more demanding, because psychologically being in the hospital, being sick and never having anyone around, worsens any symptoms. (CN 15)

Abbreviations: CN, clinical nurse; EN, executive nurse; WNM, ward nurse manager.

patients' levels. In Table 3, findings have been summarized, and the quotes extracted from interviews are also reported.

3.2.1 | System level

At system level, as the highest organizational level establishing and influencing the culture, the values and the strategic plans of the entire health care trust, poor support for nurses and nursing care were identified as the reason for unfinished nursing care. A lack of nurses and nursing care value has been underlined as leading to poor support and to a low interest in nursing-related issues, such as unfinished nursing care. Consequently, a sort of system insensitivity about unfinished nursing care has been reported, with managers more concentrated on addressing economic, organizational and reporting outcomes, failing to detect unfinished nursing care issues and to support nurses in designing and implementing preventive strategies.

Furthermore, nurses reported being oppressed by the high bureaucratization of the system, spending a lot of time on administrative work, which forces them to postpone relevant nursing care activities. On the other hand, the lack of investments in electronic records and on health care digitalization has also been reported to increase the unfinished nursing care due to the lack of data available across settings and professionals.

3.2.2 | Unit level

At the unit level, inappropriate care environments were reported as causing the unfinished nursing care. In particular, the layout of the environment was described as influencing this phenomenon, especially when there is a long distance between patient rooms and the nurse station and nurses are forced to spend a lot of time walking through the ward. Moreover, the high number of patients in each room, with all their belongings, and the chaotic environment, due to the presence of equipment in the middle of the corridors, have been reported making nursing care difficult, wasting nurses' time and leading to unfinished nursing care.

The lack of material resources has also been underlined as contributing to unfinished nursing care: Materials are often unavailable or limited, triggering the need to search for resources, asking nurse managers or other wards, thus substantially postponing the care required, making nurses' provision of care less timely. Lack of nursing care in terms of high nurse-to-patient ratio and nurse shortages have also been reported. When there is a low number of nurses available, they are expected to focus their attention on a limited set of activities, judged as high priority, leaving others missed. Moreover, a shortage of nursing aides pushes nurses to spend time on non-nursing tasks that may result in unfinished nursing care. Participants have also underlined the unavailability of physicians as a reason for unfinished nursing care, mainly during night shifts or weekends, when they spend an increased time trying to reach them in case of necessity and to obtain, for example, a medication prescription.

Ineffective inter- and intra-professional cooperation was reported as another reason. Participants have highlighted poor teamwork, describing the difficulty in feeling as a group, communicating, cooperating and having common strategies. Tensions and/or communication breakdowns with medical staff, nursing aides, ward managers and patients have been reported as reducing the coordination of work processes, increasing the risk of unfinished nursing care. Moreover, the unpredictability of work processes, requiring the continual reprioritizing of the provision of nursing care, has also been experienced as leading to unfinished nursing care: Overlapping activities and uncoordinated decisions (e.g., large number of discharges and admissions) force nurses to miss or postpone some activities. On the other hand, the constraints determined by strong, well-established routines were also considered important in leading nurses to work 'in a given manner', without reconsidering priorities and changes required by work process unpredictability. The lack of shared procedures inside of the nursing team also contribute to unfinished nursing care as well as the high frequency of interruptions (e.g., telephone and colleagues) forcing nurses to continually stop and abandon their activities to take care of something else.

Among reasons at the unit level, participants have also reported the ineffective shift design: Weekends and night shift are still designed with low numbers of nursing staff due to the old conception that during night and weekends, the care required is limited. Finally, ineffective models of nursing care delivery have been highlighted, given the prevailing diffusion of the functional model instead of the patient-centred care model due to the lack of resources. In this context, unfinished nursing care is also increased by the poor quality of the handovers, which threatens the continuity of care.

3.2.3 | Nurse managers' level

Participant clinical nurses have reported the role of the inadequate leadership as a reason for unfinished nursing care, lacking in clear and shared goals and interest in the nurse's professional growth. Specifically, ward managers have been reported to negatively affect the expectations of clinical nurses, asking them to work in a standardized/routine way, thus increasing unfinished nursing care.

3.2.4 | Clinical nurses' level

At the clinical nurses' level, ineffective nurses' performances were reported as a reason for unfinished nursing care: Increased age of nurses has been recognized as diminishing the nurse's capacity, whereas the lack of work experience, knowledge and competence may threaten an effective prioritization. The lack of professional responsibility and motivation at the individual level of nurses both have been reported as limiting the degree of engagement required to prevent unfinished nursing care. Added to this have been highlighted in the staff stress and fatigue due to the high workloads: Nurses working under pressure are at higher risk of underperforming; moreover, the lack of effective delegation to nursing aides, aimed at protecting

time for nursing interventions, increased the risk of unfinished nursing care.

Furthermore, weaknesses in education were also experienced: Specifically, the lack of transition programmes for newly qualified graduates as well as the lack of orientation programmes for the new staff entering the unit, especially during the pandemic, have increased the risk of unfinished nursing care. In addition, the high turnover, implying the need for supporting new colleagues on the one hand, and a frailty in the competences available in the staff where few experts remain in the unit, on the other, have been documented as increasing unfinished nursing care.

Among nurses, their poor humanistic view of patient care was also reported: The nursing care delivered has been reported to be more centred on activities rather than being focused on patients, overshadowing the patient, neglecting his/her priorities. Moreover, the disruption of the continuity of care due to rapid nurses' rotations across units and the fragmentation of care between part-time and full-time nurses, all threatening the in-depth knowledge of patients' needs, have been reported as affecting the quality of care. The last reasons are based on the nurses' level ineffective priority-setting skills. Some interventions (e.g., rehabilitation) require an unpredictable amount of time; thus, nurses focus their attention on more urgent and controllable interventions in terms of duration. Priorities are also identified on preventing legal/medicolegal issues—for example, filling in clinical documentation accurately to prevent errors. Erroneous nursing care planning has also been highlighted as leading to unfinished nursing care when unnecessary care interventions are programmed leaving others overlooked.

3.2.5 | Patients' level

Nurses have reported an increased demand of patient care caused by the patient's instability (e.g., at the hospital admission) and complexity due to high age, comorbidity and dependence on daily living activities. The increased needs of some patients have been reported to absorb more nursing care, thus reducing the care for those more clinically stable who are often neglected in some requests. Patients' cognitive impairments have been suggested as also negatively affecting unfinished nursing care, due to their lower cooperation and inability to express their needs, rendering their assessment more complex and time-consuming. Moreover, participants have also reported the relevance of patient loneliness, requiring additional interventions based on communication and emotional support. This is also linked to the lack of caregivers' support, determined by restrictions imposed by the pandemic, expanding dramatically the needs of patients (e.g., help in eating) previously addressed by family carers or volunteers (Bicego et al., 2021).

4 | DISCUSSION

We performed a qualitative study involving all levels of the nursing service, appointed in different units/hospitals and with different professional and educational backgrounds. Previous qualitative studies involved only clinical nurses or nurse managers (Harvey et al., 2018; Kalisch, 2006; Mantovan et al., 2020; Rezaei-Shahsavarloo et al., 2021), leaving a gap in the knowledge on reasons for unfinished nursing care as experienced by the whole nursing service.

The reasons that emerged for unfinished nursing care can be discussed in the context of (a) the conceptual frameworks available, (b) the empirical evidence summarized to date and (c) the different perceptions of nurses' roles across the whole nursing service.

To date, the reasons for unfinished nursing care have been identified in the conceptual models available (task undone, missed nursing care and implicit rationing of nursing care) mainly at the unit or nurses' levels, thus suggesting that factors are mainly embodied in the context where the nursing care is delivered. The five different levels of reasons for unfinished nursing care that emerged in our study, namely, from that at the bedside to those at the higher system levels, suggest that some factors already recognized in the conceptual models available should be expanded by including other factors at the macro-level, as proposed by Jones et al. (2019). Moreover, the different levels that emerged seem to have reciprocal influences and close connection to each other: As patients' needs shape the nursing care required, the system level might affect the nursing care and the patient expectations.

By considering the reasons documented by the empirical evidence summarized to date (Chiappinotto et al., 2022) and also in this study, the three already known levels (organizational, nurses and patients) should be expanded by including the system and the ward manager levels, both of which can influence the occurrence of unfinished nursing care. The health care system poorly supporting the nursing service, not valuing the care delivered, not demonstrating sensitivity regarding unfinished nursing care and not investing in strategies capable of easing the work of clinical nurses (e.g., electronic records; Longhini et al., 2020) substantially apply a negative pressure that leads to unfinished nursing care. Moreover, at the nurse manager level, leadership inadequacy was also reported as leading to unfinished nursing care: The importance of the leadership has already been documented (Scott et al., 2019) along with its ethical implications (Arslan et al., 2022), which may be associated with the unfinished nursing care. Different factors may affect the poor leadership of the ward managers, from the scarce training received to the consequences of high stress lived daily (e.g., Martella, 2021) resulting in burnout (Kelly & Hearld, 2020). However, also in previous studies, the inadequate leadership has been documented (e.g., Rezaei-Shahsavarloo et al., 2021) as aggravating the unfinished nursing care: for example, by further not supporting the nurses or not moderating the negative pressure applied by the system on clinical nurses.

In the remaining levels, namely, at the unit, nurses' and patients' levels, the findings confirm some factors already recognized as leading to unfinished nursing care (Chiappinotto et al., 2022; Verrall et al., 2015), whereas others are new and thus increase the evidence available. At the unit level, several reasons that emerged in our study have already been recognized as relevant (environment, material

resources, human resources, inter- and intra-professional cooperation, work process, shift design and models of nursing care delivery; Chiappinotto et al., 2022): Therefore, the evidence seems to be accumulated in a consistent direction. However, two main new reasons have emerged: (a) the lack of nursing aides in their capacity to support nurses in concentrating their efforts on nursing care and (b) the quality of handovers in keeping priorities across shifts and teams. Also, at the nurses' level, some reasons have already been documented (increased age, education, experience and competencies, responsibility and motivation, stress and fatigue, time management skill, delegation skills, turnover, part time, time required for a nursing intervention and propensity to prevent legal/medicolegal issues; Arslan et al., 2022; Chiappinotto et al., 2022; Rezaei-Shahsavarloo et al., 2021). However, three elements seem to be new in this context: (a) the poor performance of clinical nurses due to the high work pressures applied over a long time; (b) the continuity of care often threatened by the required rotations across units (due, for example, to the unpredictable understaffing), with a lack of programmed transitions (for newly qualified graduates or new staff), rendering superficial the knowledge of the patients' needs, especially those cognitively impaired; and (c) the poor humanistic vision of nursing care that also affects the quality of care plans.

The progressive increase in the complexity and instability of patients, also due to their cognitive impairments (Rezaei-Shahsavarloo et al., 2021), triggers an additional demand for care: therefore, while on the one hand data should be continuously updated in the attempt to discover whether with the increased care demand the occurrence of unfinished nursing care will increase, and on the other more awareness should be devoted towards unfinished care, especially in the case of frail patients, in accordance with their increased risk of negative outcomes. Moreover, family restrictions due to the pandemic have further increased the incidence of unfinished care, and the role of nurses to compensate for them might be insufficient given the importance of family visits for the patients, the nurses and the entire care delivery system (Hugelius et al., 2021). On the other hand, although several studies have investigated the consequences of the family restrictions also for nurses, the units without relatives might shape new attitudes among health care professionals, thus creating barriers to their further involvement.

The reasons for unfinished nursing care emerged differently across the actors composing the nursing service. Although a large number of reasons have been reported by clinical nurses, suggesting that they can identify reasons at all levels of the health system complexity, on their side, ward managers have reported some of the same reasons, but no new other factors, suggesting that they are close to clinical nurses, and perceive similar reasons, from a sort of internal (to the unit) perspective. On the other hand, executive nurses identified some additional reasons, not mentioned by clinical and ward manager nurses (e.g., a system insensitive to unfinished nursing care and ineffective delegation skills), underlining the value of the external perception of the phenomenon at the overall level. Interestingly, these two visions (internal and external to the units) are complementary and ensure a global vision of all the factors involved in unfinished care. Therefore, this suggests that both in investigating and in implementing interventions to prevent the phenomenon, all actors and levels should be included by adopting a complex approach that includes interventions at multiple levels in a comprehensive strategy (Craig et al., 2013).

4.1 | Limitations

This study has several limitations. Only one large health care trust based on multiple hospitals was approached, thus suggesting that more investigations are required to understand the reasons for unfinished nursing care across multicentre settings, also including the community levels. Moreover, more variation in participants' profiles is suggested by involving nursing services at the academic levels and/or located in different contexts (urban and rural) and countries. Furthermore, the study was conducted during the pandemic, and this might have affected the findings. In addition, we have involved nurses inside of a nursing service; upper levels (regional and national) could also be involved in future studies to merge all the perspectives regarding reasons for unfinished care; moreover, along the same lines, also involving other health care professionals (e.g., physicians) and patients may contribute to a deeper understanding of the unfinished nursing care phenomenon. Future research should also continue to develop knowledge to which profile/profiles the different reasons of unfinished care emerged are attributable and the weight of each reason as perceived by different profiles to increase the understanding of the phenomenon at the nursing service and at the entire health care system.

5 | CONCLUSIONS

To the best of our knowledge, this is the first qualitative study attempting to detect the antecedents of unfinished nursing care at the nursing service level. The map of the reasons that emerged, at their different levels, suggests three main conclusions:

- Reasons for unfinished nursing care lie at different levels, from at the system upper levels to at the bedside, involving all actors as responsibilities of nursing care.
- The detailed reasons that emerged are similar to those already established in the conceptual and empirical evidence, whereas others are new: In the first case, the accumulation of evidence in the same direction, despite its production at different times and under different circumstances/approaches (National Health Service features, countries and research methodologies), creates the basis for the design of interventions aimed at preventing the phenomenon; on the other, the new reasons that emerged may suggest future direction of the intervention studies to prevent/minimize the unfinished care.
- Clinical nurses perceived the reasons for unfinished nursing care in several different elements and similarly to the perception of ward managers, whereas executive nurses have a different perspective

of the reasons: However, their complementary views are crucial to understanding the phenomenon and to design interventions that effectively target the different reasons in a comprehensive strategy.

In particular, the changes in the patients' needs, mainly expressing a trend of increased demand for care, seem to foresee dramatic future conditions in the context of unfinished care if nursing services are not provided with increased resources and identified as a fulcrum of a system strategy aimed at preventing the occurrence of the phenomenon.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

The actors composing the nursing service perceive different reasons and therefore should be involved in detecting and contrasting the unfinished nursing care. The influences applied or established at the upper level affect the bedside levels: Therefore, strategies to prevent or minimize unfinished nursing care should consider different levels and a system-inclusive approach should be designed. Although the reasons already documented in previous studies, and confirmed in our study, should be considered as a basis on which to design interventions mainly under the complex interventions' framework aimed at preventing the occurrence of unfinished nursing care, the new reasons suggest some additional implications. The role of ward manager leadership should be further investigated in its contribution to unfinished nursing care as aggravating or moderating the factors applied by the system level. Their leadership should be promoted; however, they should also be supported when they act as a protective barrier towards nurses when the system applies a negative pressure on the entire nursing service. In addition, their poor leadership may also be considered as a sign of fatigue and burnout: Nurse leaders are instrumental in building a resilient nursing workforce, but their energy should be nurtured (Wei et al., 2019). Moreover, findings suggest that handovers should be better designed, and the number of nursing aides should be increased in order to support the continuity of care and the nursing care delivered. Managerial strategies are strongly recommended to offer nurses some respite when poor performance appears due to high pressures; moreover, the continuity of care should be encouraged by avoiding unnecessary rotations across units, by implementing strategies to ensure that the same staff are assigned to the same patients so as to have a deeper understanding of their needs and by promoting accelerated transition programmes when newly qualified graduates or new staff are experiencing difficult times. Renewed attention towards the humanistic vision of nursing care is required: This could be promoted by nursing education, by nurse leaders and by the entire system primarily considering that nurses are valuable human resources.

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CONFLICTS OF INTEREST

No conflict of interest has been declared by the authors.

ETHICS STATEMENT

According to the nature of the study, no ethical approval was required. The study was approved by the Health Care Trust Board (Azienda AULSS 2 Marca Trevigiana on March 26th, 2022).

AUTHOR CONTRIBUTIONS

All authors made substantial contributions to conception and design or acquisition of data and analysis and interpretation of data, are involved in drafting the manuscript or revising it critically for important intellectual content, have given the final approval of the version to be published and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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REFERENCES

Al-Kandari, F., & Thomas, D. (2009). Factors contributing to nursing task incompletion as perceived by nurses working in Kuwait general hospitals. *Journal of Clinical Nursing*, *18*(24), 3430–3440. https://doi.org/10.1111/j.1365-2702.2009.02795.x

Arslan, G. G., Özden, D., Göktuna, G., & Ertuğrul, B. (2022). Missed nursing care and its relationship with perceived ethical leadership. *Nursing Ethics*, *29*(1), 35–48. https://doi.org/10.1177/09697330211006823

Bicego, L., Mislej, M., Benedetto, L., & Guidi, V. (2021). The contribution of voluntary associations in the process of eliminating mechanical restraint in hospitals. *Assistenza Infermieristica e Ricerca*, *39*(1), 24–30. https://doi.org/10.1702/3371.33473 PMID: 32458827.

Caldwell-Wright, J. (2019). Letter to the editor: Perspectives of oncology unit nurse managers on missed nursing care: A qualitative study. *Asia-Pacific Journal of Oncology Nursing*, *6*(1), 94. https://doi.org/10.4103/apjon.apjon_54_18

Chiappinotto, S., Papastavrou, E., Efstathiou, G., Andreou, P., Stemmer, R., Ströhm, C., Schubert, M., de Wolf-Linder, S., Longhini, J., & Palese, A. (2022). Antecedents of unfinished nursing care: A systematic review of the literature. *BMC Nursing*, *21*(1), 137. https://doi.org/10.1186/s12912-022-00890-6

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2013). Developing and evaluating complex interventions: The new Medical Research Council guidance. *International Journal of Nursing Studies*, *50*(5), 587–592. https://doi.org/10.1016/j.ijnurstu.2012.09.010

Dehghan-Nayeri, N., Shali, M., Navabi, N., & Ghaffari, F. (2018). Perspectives of oncology unit nurse managers on missed nursing

care: A qualitative study. *Asia-Pacific Journal of Oncology Nursing*, *5*(3), 327–336. https://doi.org/10.4103/apjon.apjon_6_18

Elo, S., & Kyngäs, S. H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, *62*(1), 107–115. https://doi.org/10.1111/j.1365-2648.2007.04569.x

Harvey, C. L., Thompson, S., Willis, E., Meyer, A., & Pearson, M. (2018). Understanding how nurses ration care. *Journal of Health Organization and Management*, *32*(3), 494–510. https://doi.org/10.1108/JHOM-09-2017-0248

Hugelius, K., Harada, N., & Marutani, M. (2021). Consequences of visiting restrictions during the COVID-19 pandemic: An integrative review. *International Journal of Nursing Studies*, *121*, 104000. https://doi.org/10.1016/j.ijnurstu.2021.104000

International Council of Nurses. (2022). The global nursing workforce and the COVID-19 pandemic. https://www.icn.ch/system/files/2022-01/Sustain%20and%20Retain%20in%202022%20and%20Beyond-%20The%20global%20nursing%20workforce%20and%20the%20COVID-19%20pandemic.pdf

Jones, T., Drach-Zahavy, A., Amorim-Lopes, M., & Willis, E. (2020). Systems, economics, and neoliberal politics: Theories to understand missed nursing care. *Nursing & Health Sciences*, *22*(3), 586–592. https://doi.org/10.1111/nhs.12700

Jones, T., Willis, E., Amorim-Lopes, M., & Drach-Zahavy, A. (2019). Advancing the science of unfinished nursing care: Exploring the benefits of cross-disciplinary knowledge exchange, knowledge integration and transdisciplinarity. *Journal of Advanced Nursing*, *00*, 1–13. https://doi.org/10.1111/jan.13948

Kalisch, B. J. (2006). Missed nursing care. A qualitative study. *Journal of Nursing Care Quality*, *21*(4), 306–316. https://doi.org/10.1097/00001786-200610000-00006

Kalisch, B. J., Landstrom, G., & Williams, R. A. (2009). Missed nursing care: Errors of omission. *Nursing Outlook*, *57*(1), 3–9. https://doi.org/10.1016/j.outlook.2008.05.007

Kelly, R. J., & Hearld, L. R. (2020). Burnout and leadership style in behavioral health care: A literature review. *The Journal of Behavioral Health Services & Research*, *47*(4), 581–600. https://doi.org/10.1007/s11414-019-09679-z

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. SAGE Publications.

Longhini, J., Papastavrou, E., Efstathiou, G., Andreou, P., Stemmer, R., Ströhm, C., Schubert, M., de Wolf-Linder, S., & Palese, A. (2020). Strategies to prevent missed nursing care: An international qualitative study based upon a positive deviance approach. *Journal of Nursing Management*, *29*(3), 572–583. https://doi.org/10.1111/jonm.13176

Lucero, R. J., Lake, E. T., & Aiken, L. H. (2009). Variations in nursing care quality across hospitals. *Journal of Advanced Nursing*, *65*(11), 2299–2310. https://doi.org/10.1111/j.1365-2648.2009.05090.x

Mantovan, F., Muzzana, C., Schubert, M., & Ausserhofer, D. (2020). "It's about how we do it, not if we do it". Nurses' experiences with implicit rationing of nursing care in acute care hospitals: A descriptive qualitative study. *International Journal of Nursing Studies*, *109*, 103688. https://doi.org/10.1016/j.ijnurstu.2020.103688

Martella, S. (2021). Pandemic affected mental health of doctors and nurses. *Assistenza Infermieristica e Ricerca*, *40*(2), 112–114. https://doi.org/10.1702/3634.36150 PMID: 34180915.

Morse, J. M. (1995). The significance of saturation. *Qualitative Health Research*, *5*(2), 147–149. https://doi.org/10.1177/104973239500500201

Patton, M. Q. (2015). *Qualitative research & evaluation methods* (4th ed.). SAGE.

Regione del Veneto. (2021). Deliberazione del Direttore Generale 28/01/2021, n. 107 "Approvazione del Piano delle Performance 2021-2023 e Documento Direttive 2021 dell'Azienda ULSS N. 2 Marca Trevigiana." AULSS 2 Marca Trevigiana. https://www.aulss2.veneto.it/documents/6017636/6074298/Piano%2BPerformance%2B2021-2023%2BDDG%2Bn.107%2Bdel%2B28-01-2021/89ac74b1-8012-4d08-95b3-36736f9422bf?version%3D1.3

Rezaei-Shahsavarloo, Z., Atashzadeh-Shoorideh, F., Ebadi, A., & Gobbens, R. J. J. (2021). Factors affecting missed nursing care in hospitalized frail older adults in the medical wards: A qualitative study. *BMC Geriatrics*, *21*, 555. https://doi.org/10.1186/s12877-021-02524-z

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health*, *33*(1), 77–84. https://doi.org/10.1002/nur.20362

Schubert, M., Schaffert-Witvliet, B., De Geest, S., Glass, T., Aiken, L., Sloane, D. S., Clarke, S., Abraham, I., & Glass, T. (2005). *RICH-Nursing Study: Rationing of Nursing Care in Switzerland. Effects of rationing of nursing care in Switzerland on patient' and nurses' outcomes (final report grant, Swiss Federal Office of Public Health, Bern, Switzerland)*. Institute of Nursing Science, University of Basel. Schweizerisches Rotes Kreuz (1992) (pp. 1–18). Bern.

Scott, P. A., Harvey, C., Felzmann, H., Suhonen, R., Habermann, M., Halvorsen, K., Christiansen, K., Toffoli, L., & Papastavrou, E. (2019). Resource allocation and rationing in nursing care: A discussion paper. *Nursing Ethics*, *26*(5), 1528–1539. https://doi.org/10.1177/0969733018759831

Sochalski, J. (2004). Is more better? The relationship between nurse staffing and the quality of nursing care in hospitals. *Medical Care*, *42*(2), II67-73. https://doi.org/10.1097/01.mlr.0000109127.76128.aa

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

Verrall, C., Abery, E., Harvey, C., Henderson, J., Willis, E., Hamilton, P., Toffoli, L., & Blackman, I. (2015). Nurses and midwives perceptions of missed nursing care—A South Australian study. *Collegian*, *22*(4), 413–420. https://doi.org/10.1016/j.colegn.2014.09.001

Wei, H., Roberts, P., Strickler, J., & Corbett, R. W. (2019). Nurse leaders' strategies to foster nurse resilience. *Journal of Nursing Management*, *27*(4), 681–687. https://doi.org/10.1111/jonm.12736

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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