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Rationed or
missed nursing
care: Report to
the ANMF
(Victorian
Branch)

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Abbreviations and Acronyms

ABF	Activity Based Funding
ABC	Australian Broadcasting Service
ABS	Australian Bureau of Statistics
ACFI	Aged Care Funding Instrument
ACCRIT	Australian Centre Research Industry and Training
ADL	Activities of Daily Living
AHPRA	Australian Health Practitioner Regulation Agency
AHSRI	Australian Health Service Research Institute
AIHW	Australian Institute of Health and Welfare
AIN	Assistants in Nursing
BSL	Blood sugar level
CHADx	Classification of Hospital Acquired Diagnosis
COAG	Council of Australian Governments
CPI	Consumer Price Index
DD	Dangerous Drugs
DHSS	Department of Health and Social Services
EB	Enterprise Bargaining
ED	Emergency Department
EN	Enrolled Nurse
GP	General Practitioner
HAN	Health Assistants (Nursing)
HACC	Health and Community Care
HEWA	Hospital Early Warning system
HSU	Health Services Union
HWA	Health Workforce Australia
IHPA	Independent Hospital Pricing Authority
ISOBAR	Identify-situation-observation-background- agreed plan- read back
LOS	Length of Stay
MPC	Multi-purpose centres
NEAT	National Emergency Admission Times
NHPPD	Nursing Hours Per Patient Day
NCP	Nursing Care Plan
NUM	Nurse Unit Manager
OCI	Overall Care Index
OCIO	Office of the Chief Information Officer
OECD	Organisation of Economic
PCW	Personal Care Workers
PRN	pro re nata When necessary

PSA	Personal Service Attendant
RACGP	Royal Australian College of General Practitioners
RN	Registered Nurse
RWC	Reasonable Workload Committee
SBREC	Social and Behavioural Research Ethics Committee
VPSM	Victorian Patient Satisfaction Monitor

Executive Summary

In May to July 2015, 1683 nurses, midwives and personal care workers (PCW) and Assistants in Nursing (AiN) employed in public and private health facilities in Victoria completed the MISSCARE survey. This represents around 3 percent of the total number of nurses and midwives employed in the state of Victoria.

The survey was administered via Survey Monkey by a research team from Flinders University in collaboration with the Victorian branch of the Australian Nursing and Midwifery Federation (ANMF Vic Branch).

The Victorian MISSCARE survey is a modification on the original design developed by Beatrice Kalisch (2006). It contains eleven demographic questions, 23 questions dealing with working conditions including questions on staffing tools, 21 questions concerning missed care (care that is omitted, postponed, or incomplete) and 20 questions addressing reasons why care is omitted in the settings in which the nurse/midwives practice.

Victoria is the only state in Australia to have mandated nurse-patient ratios.

The state of Victoria is experiencing rapid growth in population.

Missed nursing care is a global phenomena linked to the rationing of health care. Nurse researchers around the world are recording the levels of missed, delayed or rationed care.

Nurses have always rationed care tasks, or prioritised them when work intensifies.

Nursing assistants known as health assistants in nursing, have been employed in some public hospitals in Victoria since 2009.

Patient satisfaction surveys conducted by the public hospitals in Victoria show high rates of satisfaction with nursing care, and the courtesy of nurses, and low scores for organisational issues such as food, restfulness of hospitals and waiting times.

There is some overlap between the patient satisfaction surveys conducted in the public hospital system and the MISSCARE survey such as length of time taken for nurses to respond to call bells, patient education, hand hygiene and medication requests.

Sixty-seven percent of nurses in Victoria are employed on a permanent part-time basis. This is higher than NSW where 48.3 percent of nurses are employed part-time permanent.

Fifty-six percent of nurses work 30 hours or more in Victoria.

Sixty-five percent of nurses and midwives prefer to maintain their current schedule.

Over 22 percent of nurses said they worked overtime greater than 20 times in the last 3 months.

Thirty-four percent of nurses and midwives worked 2 to 3 shifts over the last 3 months even though they were sick or injured, with 32 percent stating they felt an obligation to their colleagues to go to work.

Fifty-three percent of nurses and midwives felt that there were adequate staff between 100 and 75 percent of the time. The remaining 47 percent felt staffing was inadequate between 50 and all of the time.

Seventy-three percent of nurses and midwives had less than 9 patients per shift, with eighty-six percent reporting that they had fewer than 5 admissions per shift

Rounding appears to be used in 53 percent of situations, although many nurses had not heard of the term.

Nursing care tasks most often missed include skin and wound care, and glucose monitoring. The care missed is consistent across all three shifts, although some tasks are more likely to be missed on a particular shift; eg afternoon shift has higher scores for missing the promotion of PRN medications, while night shift staff report the omission of managing parenteral devices.

Nursing care tasks such as turning patients, oral hygiene, prompt medication administration and patient education are least missed.

Missed nursing care can be categorised into low, intermediate and high treatment. Lower priority care includes emotional support, patient education and discharge planning, and high priority care includes handwashing, IV/CVC lines, call bells, BSL, vital signs. Treatment (intermediate) related care is the most likely form of care to be missed. These include nursing specific tasks such as feeding, turning/positioning, wound care, administering medication on time, ambulation, mouth hygiene, and toileting. This finding is consistent with survey results from NSW.

Variables with a direct impact on missed care include the hospital location (rural hospitals report higher rates of missed care), the use of rounding impacts on missed care, and staff adequacy.

Reasons for missed care include urgent patient situations and unexpected rises in patient volumes which impact upon staffing issues. While just over 50 percent of nurses thought their ward was adequately staffed 75 to 100 percent of the time, unpredictable work increases such as increased admissions and discharges contribute to missed care. Other important reasons for missed care include: *'Inadequate skill mix for your area'*, *'an unbalanced patient assignment'* together with an *'inadequate number of assistive and/or clerical personnel'* and *'supplies/equipment not available when needed'*.

Two hundred and eighty four nurses and midwives provided qualitative comments within the survey. Responses illustrated a stronger focus on *nursing the budget*, with participants

indicating they were more aware of financial constraints or the need for profits than previous generations of nurses.

Midwives reported that early discharge of mothers curtailed adequate patient education.

Nurses and midwives targeted cost constraints, lack of adequate numbers of clerical and ancillary staff, particularly on night duty, the lack of mandated nurse-patient ratios in private hospitals, poor access to medical staff, patient acuity, and competing demands placed on nurses who are at the centre of the ward or unit. Consistent with survey results from other states, lack of access to equipment including medications also impacts on missed care.

Nurses in Victoria also indicated that poor communication was a factor in missed care.

When nurses were asked about personal issues that impacted on missed care they reported that their capacity to deliver uninterrupted care and an inability to attend case conferences as causing missed care. This was followed by the absence of hospital policies and inability to delegate work to others.

The frequencies and types of missed care are significantly influenced by both hospital/clinical unit effects including hospital location and by individual nurse/midwife factors. Missed care shows greater variation within Victorian rural hospitals.

The average frequency of missed care on Victorian afternoon and night shifts is significantly less than reported in NSW however, the average frequency of missed care on the Victorian day shift is equivalent to that reported in NSW.

Employer type (private or public agency) was not associated with missed care by Victorian respondents

The use of rounding practices in the clinical arenas presents as contributing to and preventing missed care dependent upon context.

The rate and frequency missed care is defined by the type of care missed. Intermediate treatment related care is more likely to be missed than higher priority and lower priority nursing tasks.

In Victoria, the morning shift is associated with the greatest volume of missed care, followed by the then afternoon shift and then the night shift.

Country of origin of nursing/midwifery qualifications is associated with significant variation in the frequencies and types of care missed in Victoria.

Age of the staff providing care shows a mixed but statistically significant influence on missed care in Victoria.

The gender and the level of qualifications held by the Victorian nurse/midwife is associated with significant variations in treatment-related missed care.

Staff employment status (both full and part-time employment) demonstrates variance in frequencies of Victorian missed care.

The complexity of staffs' ability to manage daily work tasks shows significance variation in missed care in Victoria..

Dissatisfaction with work teams has a statistically significant influence on Victorian missed care.

Current job dissatisfaction has a statistically significant influence on Victorian missed care.

Staffs' self-rated *level of their current health* and the *number of hours they are employed* for per week are not associated with Victorian missed care.

In order of magnitude, the reasons why Victorian care is missed care are issues associated with the provision of resources for care, communication tensions between care providers, workload (un)predictability, (dis)satisfaction levels with members of the team and workload intensity.

Chapter One:

Background to the Study

During May to July 2015 approximately 1683 nurses, midwives, personal care workers (PCW) and health assistants in nursing (HAN)/Assistants in Nursing (AiN) employed in public and private health facilities in Victoria completed the MISSCARE survey. The survey was administered by a research team from Flinders University in collaboration with the Victorian branch of the Australian Nursing and Midwifery Federation (ANMF Vic Branch). The Victorian MISSCARE survey is a modification on the original design developed by Beatrice Kalisch (2006). It contains eleven demographic questions, 23 questions dealing with working conditions including questions on staffing tools, 21 questions concerning missed care (care that is omitted, postponed, or incomplete) and 20 questions addressing reasons why care is omitted in the settings in which the nurse/midwives practice. The survey continues the exploration on Rounding from the NSW study with an additional 6 questions (See Blackman et al. 2015a). Consistent with many surveys we invited respondents to provide qualitative comments (see Appendix A for survey). This report summarises the findings.

The opportunity to conduct the survey in Victoria with ANMF Victorian Branch nurses, midwives and HAN/AiN is unique. Victoria is the only state in Australia, and one of only two states worldwide that has mandated ratio staffing for the nursing and midwifery professions. The history of this is explored in the literature review, and forms part of the analysis.

Chapter 2 of this report is a review of literature relevant to missed or rationed care. This chapter provides data specific to the health care system in the state of Victoria. Where possible, the review describes other research occurring in Victoria that adds to the understanding of missed care. The quantitative survey findings are presented in Chapters 3. The qualitative findings are outlined in Chapter 4. These are taken from the survey where nurses, midwives, health assistants in nursing and assistants in nursing were invited to provide additional comments. Over 284 participants added written comments to their survey. Chapter 5 summarises the findings.

Understanding the importance and context in rationed and missed care

A significant feature of 21st century nursing research is the impact of escalating health budgets on the quality of care (Armstrong 2009; Alameddine et al. 2012; Holland et al. 2012). This has taken many forms. It includes the nursing response to various care re-design innovations, the impact of evidence based care and the way in which new public management has intensified nursing labour (Cho et al. 2015). The phenomena of missed care is another finding emerging from contemporary nursing research (Kalisch et al. 2009; Schubert et al. 2008). Missed care is described as the “required patient care that is omitted (either in part or in whole) or delayed” (Kalisch et al. 2009). While a number of reasons are

proposed for missed care, there is strong agreement that much of it is in response to significant increases in work demands and lack of resources that are part of contemporary health care efficiency drives across a number of systems world-wide (Kalisch et al. 2009).

Continuity of care or missed or rationed care in medical and health services

Importantly missed care is not peculiar to nursing or midwifery. The global movement for coordinated care, continuity of care and multi-disciplinary care, and the hope invested in personally controlled electronic medical records are all based on a desire to ensure that the patient does not miss out on vital care. The fundamental differences between rationed or missed nursing care and rationed health or medical care and coordinated/continuity of care is one of position and professional ownership. While rationed and missed care are discourses that are now very much part of nursing and to some extent midwifery, rationed health care is seen as the prerogative of medicine, as is continuity of care, while coordinated care is understood to be a systems problem. Problems around coordinated care are dealt with through programs of care re-design such as Lean Thinking (Rees 2014). The irony is that some re-design care programs exacerbate missed care on the wards as a result of intensifying nurses' work and illustrate the flaws in coordinated care design (Blackman 2015a).

In medical circles a distinction is made in continuity of care, between the patient's perceptions and that of the practitioners (RACGP 2015). Patients define continuity of care in terms of the long term and satisfying relationship with the same medical or health practitioners, timely access, with a smooth flow from one practitioner to another or seamless care. This is also referred to as relational continuity and there is ample evidence that patients with chronic conditions experience glitches in their care that might be defined as missed or delayed care, adverse events or medical errors. The issue of delayed care is now a serious concern given the rationing of health services (Burgess et al. 2012). However, missed or rationed nursing care, and medical continuity of care is a management issue to do with consistency in care and the smooth flow of information and the required medical interventions (RACGP 2015), and to the increasing fragmentation of care as more and more is assigned to the community or to services once public, but now privatised (OCIO Health Design Authority 2012). Continuity of care includes the usual process of timely and adequate discharge planning, briefing other members of the health care team, and having access to test results so that duplication is reduced, procedures are done in a timely manner, and the care of the patient is coordinated (RACGP 2015). Burgess et al. (2012, p 182) categorise these rationed events around the interpersonal and the managerial; as errors and entry access; errors of interpersonal care, errors of coordination and management; errors of transition of care, and errors of access to family or relational continuity.

The uniqueness of nursing research on rationed care.

The relationship between escalating health budgets and missed care has been well articulated by the research team led by Papastavrou et al. (2012; 2013; 2014) and Vyrionides et al. (2014) in Cyprus, particularly the impact of the Global Financial Crisis. They situate missed nursing care within the broader context of health care rationing, noting that most nations have had to deal with curtailing health care expenditure, services and treatments in an equitable manner, given the escalating costs, the rapid advances in medical devices and the moral and ethical questions of cost versus quality of life. Papastavrou and colleagues note that while health managers and policy makers might have to make decisions about what services or drugs are provided or no longer available through publically funded services; or who is eligible and who misses out, they are sufficiently distant from the patient and their families for it not to impact on them emotionally, or for them to see it as a personal moral issue. This is not the case for nurses (and doctors), who must rationalise and prioritise the care they provide in direct face to face encounters with patients and their families. Decisions on health care funding are lived out daily by nurses who must manage within existing budget constraints and resources, understaffing and the rostering of inadequate staff skill mix. For nurses, missed care embroils them in the ethical issue about equality of access to health care on a shift by shift basis.

Papastravrou et al. (2012) also align missed nursing care with the broader quality and safety movement; a movement that is increasingly tied to models of health care funding across Europe, North America and more recently Australia (AHRSI 2013). It is clear that safety and quality in the form of patient outcomes will become part of how the Australian Federal Government moves to fund the states and territories for hospital care over the next Medicare round. The current focus of the Australian Commission for Quality and Safety in Health Care and the Independent Pricing Authority on determining the relationship between price and quality suggests this is the direction of funding reform (AHRSI 2013). The Commission has already identified 17 hospital acquired diagnosis categories, some of which are impacted on by the quality of nursing care (eg. pressure sores). The Australian Atlas of Healthcare Variation due for release in 2015 will identify differences between jurisdiction possibly at the level of hospital or region. Queensland Health is already engaged in safety incentive payments for public hospitals (Sketcher-Baker date unknown) and the OECD is using CHADx hospital acquired diagnosis as part of its framework for identifying health variations in Australia (OECD 2014). When Nurse Sensitive Outcomes/Hospital Acquired Diagnosis are identified it will be possible that missed care will be nominated as a contributing factor. Understanding how and why nurses deal with missed or rationed care will provide insights into improving the quality of patient care.

Kalisch's MISSCARE survey

The MISSCARE survey instrument was developed from a qualitative study completed in 2006 by Kalisch (Kalisch 2006). Nurses in focus groups were asked to identify the most

likely tasks to be omitted or delayed over a specified number of shifts. In Kalisch's first study and several since, nurse respondents have routinely identified discharge planning, patient education, emotional support, hygiene and mouth care, documentation of fluid intake and output, ambulation, feeding and general nursing surveillance as tasks most often missed (Kalisch et al. 2012a; Kalisch Kyung 2010; Kalisch and Williams 2009; Kalisch et al. 2009). These studies also ask nurses to identify the reasons for missed care. Nurses consistently report, unexpected heavy work increase, too few resources and lack of supplies, inappropriate nursing skill mix rostered to a shift, poor handover, inadequate orientation to the ward and poor team work, as key factors in explaining missed care (Kalisch et al. 2009, Kalisch et al. 2010, Kalisch et al. 2014). While not all these are linked to funding and resource issues, many are.

The reliability of the MISSCARE tool is demonstrated by the consistency in results across a number of domains. For example, Kalisch et al. have extended their examination of missed care to skill mix and missed care (2009), team work and missed care (Kalisch and Kyung 2010), and the impact of the work environment on missed care including the relevance of differences in managerial styles (Kalisch et al. 2012a). Kalisch has also investigated the relationship between missed care and public/private services, and differences across health care systems with varying cultures (Kalisch et al. 2012b). This is relevant in those countries where families provide some of the Activities of Daily Living (ADL), the relationship between medicine and nursing is more hierarchical, or fewer allied health professionals are employed. The culture of the broader health care team, specifically the norms governing communication and capacity to work together in multidisciplinary teams is often cited as one explanation for missed care (Kalisch et al. 2012a).

Studies on missed care also highlight the impact of specific policies on the organisation of nursing work, particularly where nurses are afforded the opportunity to identify why care is missed. For example, one of the explanations for missed care, identified in the NSW study (Blackman et al. 2015a) is the impact of sudden patient influxes. In that study nurses reported that the National Emergency Admission Triage 4 hour rule (NEAT), which requires hospitals to ensure patients presenting at Accident and Emergency Departments wait no longer than 4 hours before being admitted or discharged, results in sudden rises in admissions in order to meet throughput targets. It is at these times that care is most often missed.

Extension of missed care to patient observations

Kalisch has extended the MISSCARE study to patients through the MISSCARE-Survey-Patient (Kalisch et al. 2012c). This instrument has been devised using a similar methodology to the MISSCARE tool for nurses. It was drawn up following interviews with patients immediately following their discharge. In these interviews patients were asked to identify factors about their care that they thought were missed, delayed or inadequate. The survey items were

identified from the recurring themes, however, because patients are not fully aware of all the care work performed by nurses, the MISSCARE-Survey-Patient tool separates out those tasks readily obvious to patients from those that are either hidden or only partially understood. Obvious tasks include mouth care, while hidden tasks might be surveillance of monitors that record patient's vital sign, that are out of the patient's sight or difficult to decipher. Kalisch et al. (2014) have tested this survey in one major study to date with findings consistent with nurse responses. Similar work has been done by Papastavrou et al. (2014). They found patient satisfaction correlated with nurse's perceptions of the care they missed, although it was difficult for them to identify the tipping points or balance between high levels of patient dissatisfaction and high levels of missed care.

Prioritising care

The various studies conducted by Kalisch et al. (2012a) and Papastravrou et al. (2012; 2013; 2014) point to hierarchies of missed care. There is some evidence these hierarchies differ according to country, region and type of hospital. Certainly, in those countries where relatives perform some activities of daily living for patients, there are variations from the USA, Australian and New Zealand data where relatives are not expected to perform ADLs. In the NSW study we discerned a hierarchy of missed care reflective of Alfaro-Lefevre's (2008) model for nurse prioritisation. We categorised the 21 items in the Kalisch MISSCARE survey in line with the Alfaro-Lefevre list of nursing tasks; intermediate, high and low priority tasks (see Table 1.1). The classification allocates surveillance of patient vital signs to the higher priority list, while treatment related problems (e.g. minimising infection) are assigned to the intermediate or level 2 category, and documentation, and emotional work are assigned to level three priority nursing care (lower priority nursing care) (Alfaro-Lefevre 2008). The results of the NSW study indicate that nurses tended to prioritise level 1 and 3 tasks over level 2 or intermediate tasks, but were also more likely to miss level 1 tasks than level 3 (Blackman et al. 2015). This is counter intuitive, and differs from other studies (Verrall et al. 2015). However, it is consistent with research by Papastravrou et al. (2012; 2013; 2014). Their studies point to the intermediate (level 2) tasks as the most often missed and highlight the differences in health care system cultures in the provision of nursing care. Nurses in the Papastravrou et al. studies reported that some care tasks could be left to relatives such as bathing, feeding and toileting. However, they also noted differences across nurse specialties suggesting this prioritisation is not uniform and is indeed carefully monitored by nurses in the interest of patient care. Consistent with our own research level 1 tasks are the most reliably performed, with Papastravrou et al. explaining this as a result of nurses following the medical model.

Prioritising as stacking

Ebright (2010: 4) provides some insight into the relationship between nurse prioritisation and dissatisfaction using the concept of stacking. She argues that on any shift, nurses

engage in constant re-prioritising or stacking of their work in response to an environment that includes the patients that make up their load, but also the various environmental, cultural and resource factors at play over the 8 hours. She defines stacking as *the invisible, decision-making work of RNs about the what, how, and when of delivering nursing care to an assigned group of patients*, and notes that it is informed by nursing knowledge as well as the knowledge of the complexity of the wider environment. Importantly, she notes that the Kalisch studies identify nurse’s perceptions of why care is missed, but do not identify whether it is a result of forgetting, deliberate omission, or the outcome of dealing with competing demands. Nor does this research indicate whether the nurse consciously decides to omit some tasks over others, given the work demands and the patient needs.

What is clear from the research is that several studies with a focus on health care safety and risk reduction have moved away from blaming the individual health professional, to examining the system. These studies identify issues such as missed equipment, supply problems, interruptions, waiting for a particular resources needed, and lack of time (Ebright 2010; Kalisch et al. 2009). Interestingly, all three researchers have taken different approaches to naming the problem, yet have come up with similar system wide deficits; Kalisch on missed care, Ebright on underlying rationale for stacking, and Aiken on staffing levels. Where these deficits within the system prevail, nurses are forced to constantly cognitively re-adjust to the situation drawing on their expertise. This requires a high degree of mindfulness to continuously re-order, delegate, and re-prioritise or stack in an environment charged with uncertainty and risk. This is also particularly difficult should the nurse be on duty while unwell and it is highly possible that when the trade-offs become too stressful, such as when core nursing tasks are sacrificed, that this leads to high levels of dispiritedness with the profession.

Table 1.1: Hierarchy of missed care items after Alfaro-Lefevre (2008)

Lower Priority	Intermediate or treatment-related priority	Higher priority
Input/Output	Ambulation	Vital sign
Documentation	Feeding	Hand washing
Patient Education	Turning	BSL
Affect support	Sit up	Assess
Discharge Planning	Med Administration	Iv Lines
	Hygiene	Responding to Call Bell
	Mouth wash	
	PRN Med	
	Effect of medication	
	Toileting	
	Wound care.	

Other nursing workforce research occurring in Australia

In presenting results we aim to triangulate our results with related or similar research occurring in Australia. For example, research by Holland et al. (2012) that duplicated the Australian Worker Representation and Participation Survey (AWRPS) in 2011 conducted through the ANMF portal found overall that nurses were less satisfied with their employment conditions than workers in other industries, although they continued to enjoy their work. The study is of interest on a number of fronts. Firstly, it is an international study allowing for national and international comparisons across a range of countries and industries, and secondly, the sample, while small, reports high levels of stress primarily a result of what nurses see as unreasonable and unsafe working conditions. This was both in terms of skill mix and staffing levels. Table 1.2. below outlines the differences in nurse's views from that of the wider workforce with data taken from the author's previous studies. In all six categories, nurses rate their profession lower than other occupational and professional groups.

Table 1.2: Comparison of nurses views of work with other industries (AWPRS)

Items	Other industries' Percentage	Nurses' Percentage
Intention to leave the profession	4	15
Report favourable on Industrial climate	71	41
Content with pay and working conditions	75	40
Management responds to issues of concern	59	28
Power and authority shared	42	29
Control over the organisation of workplace	40	19

The ANMF has also conducted a number of studies on the relationship between nurse staffing levels, skill mix, and patient safety (Armstrong 2009; Adrian 2009). Armstrong's study reported on literature that noted the relationship between nursing errors of omission and patient outcomes as well as increases in patient Length of Stay (LOS) where the skill mix was inadequate. Adrian's 2009 paper examines the role of the unregulated care worker industry for unlicensed health and nursing assistants arguing that they be trained to provide a base level of care under supervision by an RN or EN in the interest of patient safety, particularly in residential aged care. The employment of unregulated health workers such as Assistants in Nursing (AiNs) and Health Assistant (Nursing) has implications for patient safety issues such as missed care. Nearly all states in Australia now employ unregulated levels of workers who perform various nursing tasks in hospitals and residential aged care settings. These workers are part of the secondary labour market where work is low skilled, and wages and working conditions less favourable than that provided to higher skilled professionals such as nurses. There is some evidence that the secondary labour market has a number of

'new migrants' employed as AiNs or Personal Care Workers, particularly in residential aged care (Australian Survey Research Group 2011).

The various issues outlined in this chapter point to macro factors impacting on how nurses manage their day to day caring work. In Chapter 2 the methodology is outlined, as well context. Understanding the specific factors impacting on the state of Victoria is also key to understanding missed care.

Chapter Two: Study Methods and Context

The survey approach

The MISSCARE survey was completed by 1683 nurses, midwives and Personal Care Attendants/Assistants in Nursing (AiN) in the state of Victoria between May and July 2015. Survey items were modified to align with Australian and Victorian nursing profession terminology and in consultation with the ANMF Victorian Branch to ensure the questions captured factors of importance to the profession in the state. This included questions to do with rounding, staffing models, ratio staffing, and the use of Assistants in Nursing. A number of questions that formed part of the South Australian and NSW study were kept for purposes of comparison. The Social and Behavioural Research Ethics Committee (SBREC) at Flinders University conducted ethics review with final approval received on October 29, 2014.

Survey Monkey was used to administer the survey with recruitment managed through the ANMF Vic Branch. The survey was advertised via e-newsletter for all members with email invitations with a direct link to the survey forwarded to members working in the public sector. Confidentiality was assured and members were reminded that the data was secure and only available to the research team. A total 1683 nurses and midwives completed the survey. This is approximately 3 percent of the total membership of 54,690 public sector members, and considerably less than the response received from nurses in NSW where over 4000 nurses and midwives responded to the survey. One possible factor is survey fatigue. The Branch responds to requests from a number of researchers and this may have impacted on results. A further explanation may be that nurses had just secured a guarantee by the Victorian Labor government that ratio staffing would be maintained (ABC News 2014).

The quantitative data was analysed using *SPSS Version 20*. The results are discussed in Chapter 3. The participants were also invited to provide qualitative comments. These are presented in thematic form in Chapter 4.

The remaining sections in this chapter outline some of the key features of the health care system in Victoria that are a backdrop to the issues impacting on nursing work in the state. The focus is on demographic trends, as well as particular programs in place within the public health sector in Victoria, and where information is available, the private for profit sector.

Demographic data

A key issue driving much health reform in Victoria and by default nursing, is estimates of population growth over the next two decades which is predicted to top 6.45 million by 2022; with an uneven spread between metropolitan and rural areas at approximately 4:1. There are 86 public and a large number of private hospitals in Victoria (74 overnight and 86 day only centres). The majority of hospitals, both public and private are urban based. For example, 40 percent are clustered within a 10 km radius of the Melbourne city centre,

serving less than 20 percent of the population, while the remaining 80 percent of the population have varying access to the other 60 percent of hospitals. The 86 public hospitals are further subdivided with 21 linked to major health service networks; 22 to sub regional health services and the remaining 43 to smaller services in rural areas. A small number (7) of bush nursing hospitals are staffed solely by nurses. The private hospitals range from those limited to same day procedures to those offering over-night care; this includes both for profit, and not for profit services (State Government of Victoria 2012).

Statistical data dealing with public health care within the state of Victoria is divided between Melbourne and rural/country Victoria. Melbourne is divided into 10 divisions; Inner east, Inner north, Inner southeast, Inner west, Northwest, Outer east, Outer northwest; Outer west, Peninsula and Southeast. Growth within these 10 regions is uneven with the Outer west expected to grow by 42 percent between 2002-2022, while the Inner east less than 7 percent (State Government Victoria 2011; 2014a). Funding is further divided on a regional basis between 8 regions with 5 rural and 3 metropolitan regions. Along with other states and territories in Australia, public funding for hospitals is in a state of uncertainty with less than 40 percent coming from the Federal government (3.8 billion of a total of 8.7 billion for the 2013-2014 financial year)(State Government of Victoria 2014b). Thirty-two percent is spent on public hospitals (State Government of Victoria 2014b). The Federal government has reduced funding for public sector services, while at the same time tying it to increased productivity and efficiency gains; which in turn is increasingly linked to safety and quality (State Government of Victoria 2012). Along with other states and territories the Victorian Government has signed up to the National Health Reform Agreements which have seen its federal funding reduced as a result of the Specific Purpose Payment model where funds are tied to activity (State Government of Victoria 2014b). By 2017 the Commonwealth contribution will be further tied to the Consumer Price Index (CPI) and population growth, along with a continuation of the Activity Based Funding (ABF).

Rationed care in the state of Victoria

Concern for continuity of care in the Victorian Health Department has been a prime focus for some years. The Chief Information Officer instigated a Continuity of Care Adoption program in 2013 (OCIO Health Design Authority 2013). The focus of these programs has been on discharge planning, and electronic records with views divided on whether or not there should be direct communication with the next practitioner or a central repository for all patient records. These issues go to the heart of missed or delayed care at a system wide level. What this approach fails to take account of is the work intensity now part of all health professionals' working lives. Rationed care is indeed a system's problem, but not necessarily one that is solved entirely through instigating electronic fixes, or as is the case in nursing; introducing rounding.

The Victorian Health Department has several programs in place to deal with safety and quality in health services. These include a program to increase hand washing compliance by health professionals (79 percent compliance up 9 percent on national average), a reduction in hospital acquired infections (from 0.9 to 0.2 less than the national average), and rates of unplanned admissions which are well below national averages, (Eg myocardial infarction 2.3 as against the national average of 3.7; heart failure 7.2/10.3; hip replacement 2.8/2.5; knee replacements 5.7/6; and paediatric tonsillectomy 2.1/2.2). Targets for elective surgery remain below the prescribed levels except for those nominated as priority one. A state wide hospital early warning system (HEWS) operates to divert ambulances when a particular hospital's A&E is at capacity (State Government of Victoria 2014b).

Nurses, Midwives and Assistant in Nursing in Victoria

There are 64,562 Registered Nurses and 19,766 Enrolled Nurses in Victoria with a total of 86,110 general nurses, up from 59,598/19,675 in 2012. Seven thousand, eight hundred midwives are registered in Victoria. A total of 208 Nurse Practitioners are registered with a further 96 endorsed to prescribe medications along with 26 Midwife practitioners. Similar to NSW there are a small, but significant numbers of nurses registered with qualifications restricted to practice in disability, paediatric or mental health nursing, the majority of these nurses being from the UK. The total number of female nurses is 76,974 with males at 9,136 (9.72 percent) down from 8,468 (10 percent) in 2012. (AHPRA: Nursing and Midwifery Board of Australia 2015). The attrition rate for nurses is around 6 percent, with the highest percentage (14 percent) in the 50 to 55 age category (State Government of Victoria 2014b). Union membership is high in Victoria, probably a reflection of its robust industrial heritage evidenced by the long protracted industrial action for a professional career structure in the 1980s under the leadership of Irene Bolger and its success in gaining nurse-patient ratio staffing in 2001 and confirmed in the most recent enterprise bargaining agreement. Public sector membership is 35,228, the private sector numbers are 9,494 and 9,968 nurses and PCWs from residential aged care sector are members (Pers comm Lisa Fitzpatrick 2014).

An analysis of the nursing workforce was conducted in 2004 by the State Government with an attempt to predict requirements into the future (State Government of Victoria 2004). Taking account of acute hospital, residential aged care, community, domiciliary and mental health, estimates put the total increase required at 21 percent for RN (Division 1) and 17 percent for ENs (Division 2) based on 2002-3 figures, noting a predicted overall deficit of around 11,000 with an estimate of 65,000 nurses needed in total across the sector. This estimate is well below the current number of 86,110 reported by AHPRA as having registration (2015). These predictions were estimated on the number of acute, sub-acute and same days separations in the public sectors reaching just under 1.2 million (State Government of Victoria 2004), whereas it is now known the number of separations for public hospitals reached 1.560 million in 2012 (State Government of Victoria 2014). The

predictions made in 2004 for 2012-13 nurse requirements were based on the then current EB agreements and a range of other measures including graduate numbers, and migration.

Division 2 nurses (enrolled nurses) constitute around 23 percent of the nursing workforce in Victoria. Around 15 percent of nurses in the public sector are registered in Division 2, as enrolled nurses but they are concentrated in the sub-acute areas, with only 7 percent in the acute hospital sector in metropolitan Melbourne. The 2004 report on the Nursing Workforce proposed an increase in enrolled nurses, including up-skilling, along with an increase in personal care attendants to fill the predicted supply and demand gaps (State Government of Victoria 2004). In the 2013-2014 financial year 1,468 new nurse graduates were employed in the public system, along with 674 allied health graduates (State Government of Victoria 2014c).

The Victorian public health system has employed health assistants (nursing) since 2009 to work under the direct supervision of a RN or EN performing mainly Activities of Daily Living (ADLs), documentation and ensuring a safe and clean environment (State Government of Victoria 2014c). The initial trial of the program demonstrated high levels of patient and RN/EN satisfaction with the work of health assistants with the key ingredient to success being team work. Table 2.1 outlines those tasks of Health Assistants that overlap with specific missed care tasks. Their employment focuses on the need for the profession of nursing to be clear about the skills mix on wards and units, and the capacity to delegate with confidence. Estimates of salary savings of up to \$6000 per person are reported where a Health Assistant is employed rather than a RN (State Government of Victoria 2014c).

Unique characteristics of nursing and midwifery in Victoria

As noted in the introduction, nursing and midwifery in Victoria presents a unique case study for measuring missed care because of the range of nursing focused initiatives or agreements. Victoria is the only state to achieve mandated ratio nurse-patient staffing levels. Several other programs are also in place that shed light on nursing in Victoria. These include a project on training nurse managers in performance management (Shaw and Blewett 2013); a guide to employing health assistants (Nursing) (State Government of Victoria 2014c), and union and the health department programs to combat violence in hospitals. As a result of union campaigns on the issue of violence, a taskforce was established in 2004, resulting in the Victorian Taskforce on Violence in Nursing Report (2005). Data suggests up to 14,000 violent code grey and black events occurred in Victorian public hospitals in the 2012/3. The 2005 Report notes that nurses who are subject to violence report that they are more likely to make a clinical error or miss care.

In 2013, the union published a policy on fatigue, specific to shift work. This policy focuses on issues such as length of shift, roster patterns, overtime, time between shifts, the timing of shifts and the demands of the work, including the overall environment. The policy draws on

risk management strategies to overcome the negative impact of work place fatigue that includes adequate staffing and puts the onus on the relevant Occupational Health and Safety officers to ensure implementation (ANMF Vic Branch 2013). This policy drew on considerable research around Australia on the impact of shift work on worker fatigue (ANMF Vic Branch 2013). However, the relationship between missed care and shift work has not been explored to any depth, although the union home page now hosts work by a South Australia research team highlighting the links. The shift work study suggests that nurses report trouble sleeping on work days at higher rates than days when they are off duty (30/20 percent), and lower sleep duration. Nurses also report they were more likely to perform errors, to miss noticing errors made by other workers and to sustain injuries when fatigued as a result of shift work (Dorrian et al. 2015)

Table 2.1: Tasks performed by HA (Nursing) measured against MISSCARE tasks

Based on (State Government of Victoria (2014c)

Health Assistants role description	MISSCARE items in survey
direct patient care: Assists patients with such tasks as hygiene and personal grooming	Patient Hygiene Patient Oral Hygiene
– nutritional needs	Feeding patients while food is still warm Setting up meals for patients who feed themselves
– mobility, transfers and positioning within the ward	Assist in ambulating three times a day or as ordered Turning patients every 2 to 4 hours
– elimination needs	Assist with toileting needs within 5 minutes of request
• patient escort	
• care of the deceased person	
• manual handling	
• pre-operative shaves	
• packing/unpacking patient belongings	
• maintaining a safe patient environment	
• safeguarding patient privacy	
• direct supervision of patients at risk (such as falls).	

<ul style="list-style-type: none"> • assist with making beds 	
<ul style="list-style-type: none"> • recognise and report adverse incidents promptly. 	
Examples of indirect support	
<ul style="list-style-type: none"> • limited documentation (including bedside notes such as noting meals or toileting, but excluding clinical/progress notes)• 	
<ul style="list-style-type: none"> • information systems 	
<ul style="list-style-type: none"> • team communication 	
<ul style="list-style-type: none"> • occupational health and safety 	
<ul style="list-style-type: none"> • maintaining stock levels of medical supplies 	Supplies/equipment not available when needed

The industrial landscape in Victoria: ratio staffing

Nurse-patient ratios are mandated in Victorian public hospitals as a result of the 2000-1 Enterprise Bargaining round. The 2001 EB award set the ratios at 1 to 4 patients across all shifts. In the 2004 round this was altered to reflect ward level staffing and became 5-20 staff in order to allow for some flexibility in responding to patient acuity (Gertz and Nelson 2007). The 2012-2016 Enterprise bargaining award for nurses working in public hospitals in Victoria makes provision for a number of factors relevant to the missed care survey results with working time being the most relevant. The award covers nurses in the public sector, although some ENs choose to have union membership with the Health Services Union (HSU). Under the public sector EBA the skill mix in acute medical and surgical wards for the employment of ENs is limited to between 20 percent to one third, depending on EN or RNs years of experience and the hospital's classification. Midwifery case load models of care are supported (Fair Work Australia 2012).

Literature exploring the impact of mandated staffing ratios is mixed. For example, a number of nurse researchers have demonstrated that the number of nurses is only one factor, a further exacerbating issue is skill mix (Twigg et al. 2012). This is highly relevant to managerial responses to missed care, and efficiency. A number of jurisdictions, including Victoria have moved to employ Health Assistants in Nursing/Assistants in Nursing (AiNs). While AiNs may perform a number of discreet, delegated nursing tasks, they do not have the education of registered nurses and while the work may be completed, they may not

necessarily impact on patient outcomes, although their presence may impact on RN rates of burn out. Research noting the impact of mandated ratios in the state of California has established that the employment of RNs does increase where previously it had been below the mandated number, but numbers may also reduce, where hospitals previously met the set target (Sochalski et al. 2008). The difficulty for Victoria is that the agreement only covers public hospitals, not the private sector.

The Victorian Branch of the ANMF commissioned a series of surveys on working conditions in the public health sector for its members; 2001, 2003, 2006, in preparation for enterprise bargaining rounds. The 2003/4 survey by Buchanan et al. (2004) sampled 2000 nurses with a response rate of 43.4 percent. Consistent with findings throughout Australia the nursing workforce was older and characterised by high levels of skill and experience. Fifty-six percent of nurses reported that they worked over-time simply to maintain patient care. This study was done soon after the introduction of patient-staff ratios of 4-1 or 5 to 20, with over 50 percent of nurses reporting they would leave the profession if not maintained, although in a later question most nurses reported that ratio staffing had not increased the number of nurses rostered onto the ward (49 percent). In the Buchanan et al. study the Nurse Unit Manager was responsible for ensuring ratio staffing was adhered to (44.8 percent), or another nurse on the ward (32.6 percent). The 50 percent rule that allows managers to round up or down was seen as problematic. The range of tasks contributing to increased workload included paper work, and changes in patient acuity, and throughput or the re-organisation of services.

At the time of the Buchanan (2004) study 56 percent of nurses were employed permanent part-time with the 50 percent working 22 and 39 hours per week. Thirty one percent worked more than 40 hours per week. Over 60 percent said they worked overtime either paid or unpaid (62.1 percent) with 21.8 percent claiming they were never reimbursed for overtime. One quarter of those surveyed worked at least 2 hours per week unpaid overtime, while 3.5 percent claimed to work up to 10 hours or more overtime. When asked why they worked overtime, nurses said they needed to do so in order to maintain basic standards of care (56 percent), that it was expected by their peers (5.6 percent), or they were a manager and it was expected of them (10.8). Staff shortages was listed as the major reason for increased hours of work (27 percent), while in response to another question directed at those nurses who had reduced their hours the reason was the Job stress became too high (21.4 percent).

The major finding of the 2006 survey was that while working hours remained constant, work intensity increased with 79 percent of nurses reporting that they were doing more with fewer resources. There was a strong belief that the staffing ratios established in 2001 were inadequate for 2006 (Wise 2007 p. 1). In the 2006 study nurses reported that the 2001 staff ratio did not take account of increases in administrative workload, work intensification,

increased patient acuity and faster patient turnover. One of the features of the staff-patient ratio is the 50 percent rule which allows managers to exercise their discretion in allocating the correct ratio per shift. Nurses reported that managers were more likely to round down, rather than up despite increased work intensity. When ratios were not adhered to, fewer than a quarter of the 1680 nurses who responded to the survey, noted that wards or beds were closed. Up to 11 percent of nurses reported working 45-49 hours, with another 11 percent reporting over 50 hours worked per week. There was an increase in the percentage opting for part time work between the 2003 and 2006 survey dates (60-66 percent), and 62 percent reported they worked overtime with over 50 percent indicating they were not paid for this work. Reasons provided for overtime included 'unavoidable...needed to maintain basic standards of care (58 percent), and 10 percent said management asked them to do overtime. The reported work intensification also resulted in shorter meal and tea breaks. However, over-all nurses believed the ratio staffing model had prevented further deterioration of working conditions (Wise 2007).

Both the 2004 (Buchanan et al. 2004) and 2006 (Wise 2007) survey by ACCRIT note the impact of short shifts on workload (7 hours instead of 8). In the 2006 survey, one third of nurses reported they worked in areas where short shift policies were in place. This included theatres, and high care residential aged care. The impact of short shifts included an uneven spread in workload, and insufficient time to complete paper work. Overall respondents believed their work intensity had increased, patient throughput and acuity had exacerbated, and there was a high level of resistance to the introduction of non-nursing staff such as Assistants in Nursing. Despite this, AiNs were introduced into some Victorian public hospitals in 2009 as a pilot program (Adrian 2009).

Patient information

The total number of patients admitted to public hospitals has increased over the last five years from 1.457 million to 1.560 million (2008-9 to 2012-13). The total increase in bed days increased just under 4 million to 5 million between 2000 and 2013. The population growth over the same period went from 3.4 to around 4.3 million (State Government of Victoria 2014b) with the state health department readily admitting that this growth had not been predicted and the health system is having difficulty keeping pace. The cost per casemix separation in 2008-9 was \$4380, increasing to \$4693 in 2001-12. Figures beyond this are not available (State Government of Victoria 2014b). The total number of beds in 2012 was 20,000 with the private sector holding around 33 percent (State Government of Victoria 2004). Table 2.2 provides the increase per 1000 population in same and multi-day admission across all Victorian hospitals for the period 2004-2005 to 2009-2010.

Table 2.2: Increase in same-day and multi-day admissions in Victorian hospitals

	2004-2005 population	per 1000	2009-2010 per 1000 population
Same day admissions	137		148
Multi-day admissions	109		112

Adapted from State Government Victoria (2012a).

Patient satisfaction surveys

In the NSW study of missed care conducted in 2014 (Blackman et al. 2015a) additional data from NSW Health that pointed to increases in productivity and efficiency within the public health care systems, specifically the hospital system was provided for comparison. This included the finding from patient satisfaction surveys conducted within the public hospital sector. While not specifically focused on missed care there were a number of questions in this comprehensive data that provided crude measures of patient's observations about the work load of nurses within the period under investigation as well as measures of specific tasks, such as discharge planning and hand washing (Bureau of Health NSW 2013). This was more difficult to do for the state of Victoria as the data was not as up to date and results from the current patient survey are not freely available. The Victorian health sector has moved to a new patient satisfaction survey and to date no results have been published (pers comm Cathy Fraser, DHHS).

However, the Victorian Patient Satisfaction Monitor (VPSM) was conducted up to 2013 for a period of 12 years. The VPSM is a 25 item index measuring six areas of satisfaction; access and admission, general information, complaints, treatment, physical environment and discharge and follow up. Between 2001 and 2009 the scores sat at just under 80 percent with the Department reporting an overall score of 73 (State Government of Victoria 2012). Response rates sat between 38 percent and 37 percent for the period 2005-2013 with more women than men responding (State Government Victoria and UltraFeedback 2013). The index records patient satisfaction scores using a 5 point scale where 5 is excellent and 1 is poor. In the 2012-2013 report, *courtesy of nurses* rated the highest score of 4.38, while respondents were least satisfied with the; *quality of the food, facilities for storing their own belonging, waiting room comfort, restfulness of hospitals and temperature of hot meals* (range 3.55-3.68) (State Government of Victoria and UltraFeedback 2013).

The VPSM is able to establish an overall care index (OCI) from the 25 survey items, some of which relate to the missed care items and are listed in Table2. 3 below.

Table 2.3: Patient satisfaction items matched to MISSCARE items

VPSM items	Score	Related missed care items
Clarity of information on admission	3.83	
Responsiveness of nurses	4.22	

Length Time nurses took to respond	3.96	Response to call bell within 5 minutes
Explanation of treatment	4.07	Patient education about illness, tests and diagnostic studies
Communication between staff	3.98	
Help received for pain	4.21	PRN medication requests acted on within 15 minutes
Explanation of purpose of medicine	3.99	Assess effectiveness of medication
Opportunity to ask questions	4.12	
Staff willing to listen to problems	4.08	Emotional support to patient and family
Written information management at home	3.86	Patient discharge planning and education
Explanation of medicines to take	3.99	
Hand washing – all staff	61 percent	Nurse Hand hygiene
Received help with meals	37 percent	

Responses to other questions asked of patients were reported in percentages. For example 61 percent of patients reported seeing staff wash their hands between attending patients all the time, but only 37 percent received help all the time to eat their meals (State Government Victoria and UltarFeedback 2013). The Annual report for 2013 noted an overall improvement in scores in the care index from 2012 to 2013 from 79.1 to 79.9 (State Government of Victoria 2014b).

Concluding comments

As outlined above, the considerable population growth in Victoria has exacerbated the pressure on the public health care system. However, the introduction of ratio staffing should mitigate the pressure put on nurses. Chapter 3 provides an overview of the survey results with commentary on how this relates to those factors unique to the state of Victoria.

Chapter Three: Results of the survey

Demographic and descriptive results

A total of 1683 survey responses were received from Victorian nurses, midwives and Assistants in Nursing (AiNs). Results of the survey are presented in this chapter primarily through the use of charts for ease of interpretation. Up to 39 percent did not complete all aspects of the survey (646 nurses and midwives) including basic demographic data. As a consequence, the data presented here is based on the number that completed the survey in full (N=992)

The data presentation includes demographic and descriptive data, identification of those nursing tasks most often missed or rationed and where relevant differences between shifts. We have also commented on the impact of rounding on care, whether or not a particular workload management tool is operational, issues of delegation and any obvious hierarchy of missed care items (Alfaro-Lefevre 2008).

The gender and age distribution of nurses who responded to the survey in Victoria mirrors that of data collected in NSW and South Australia, only 6 percent of male nurses responded to the survey, with 94 percent being female (Figure 3.1). This is less than the state ratio of male to female nurses of 9.72 percent/90.28 percent (AHPRA: Nursing and Midwifery Board of Australia 2015). The majority of nurses and midwives were in the 45 to 54 (28 percent) and 54 to 65 age (28 percent) categories which is similar to the NSW nurse/midwife profile of 30/31 percent, although higher percentage can be found in all other categories, particularly the younger age cohorts, reflecting the significant increase in the overall population in Victoria. The median age group for this cohort was between 45 to 54 years of age (Figure 3.2).

Figure 3.1: Gender characteristics of the Victorian nurses/midwives.

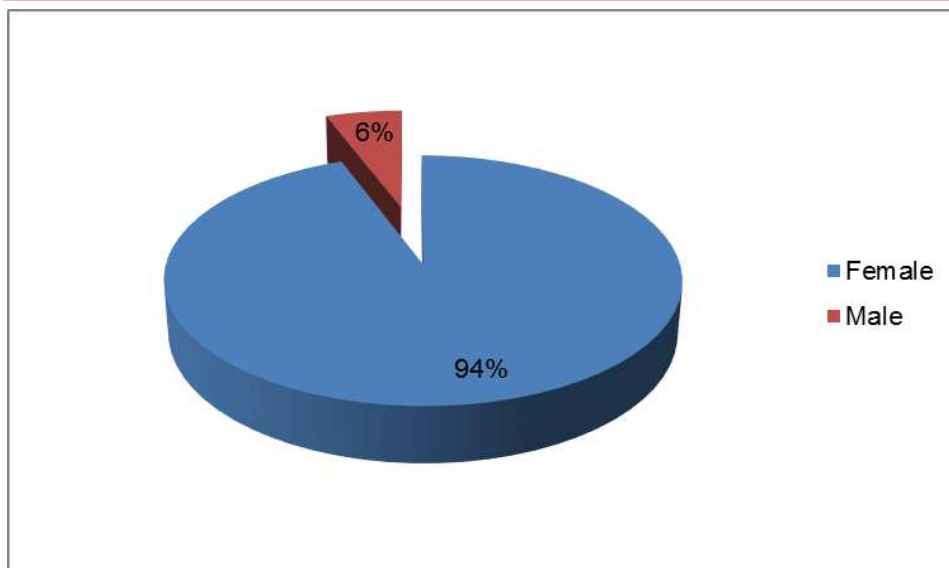
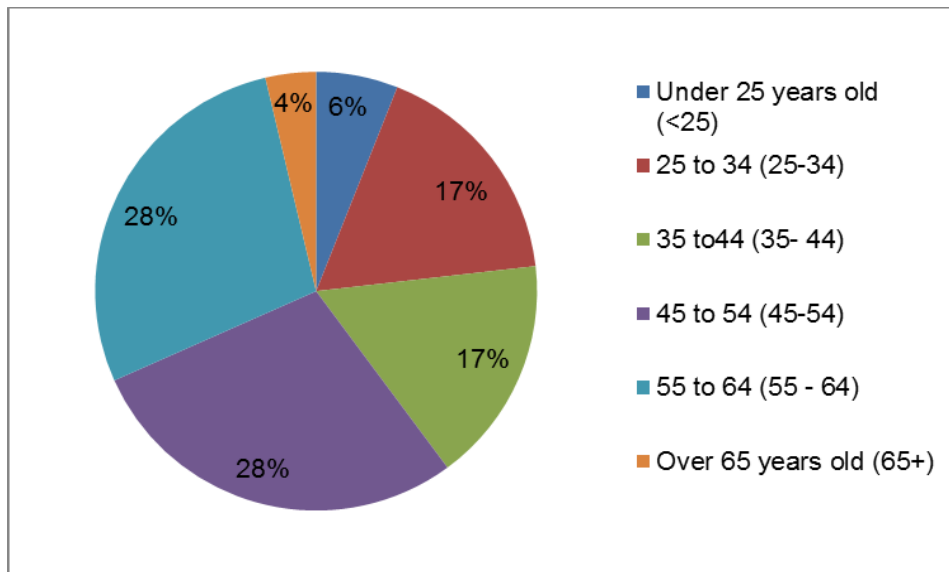


Figure 3.2: Age distribution of the Victorian nurses/midwives.



Employment characteristics

Just under three quarters of all respondents (see Figure 3.3) indicated they were employed in the public health care sector, with just over one quarter employed in the private sector. This is consistent with data from NSW where 25.4 percent of respondents to the missed care survey came from the private sector (Blackman et al. 2015a; Blackman et al. 2015b). Only 1 per cent worked with an agency. The total number of beds in 2012 across Victoria was 20,000 with the private sector holding around 33 percent. This suggests that nurses working in the public sector were more likely to complete the survey (State Government of Victoria 2004).

From Figure 3.4, it can be seen that most nurses/midwives are employed in metropolitan acute public hospitals (47 percent) with another 21 percent working in acute care located in regional settings. This is consistent with the distribution of hospitals in Victoria with the majority of them located within the city of Melbourne. Sixteen percent of the surveyed staff are employed in the residential care sector. The remaining staff (approximately one quarter of all the respondents) are employed across varying settings including mental health services, rehabilitation and geriatric treatment centres. It is not possible to make other comparisons with NSW survey data as the hospitals were categorised in terms of peer groups, which was not the case for the Victorian study.

Figure 3.3: Workplace distribution of the Victorian nurses/midwives

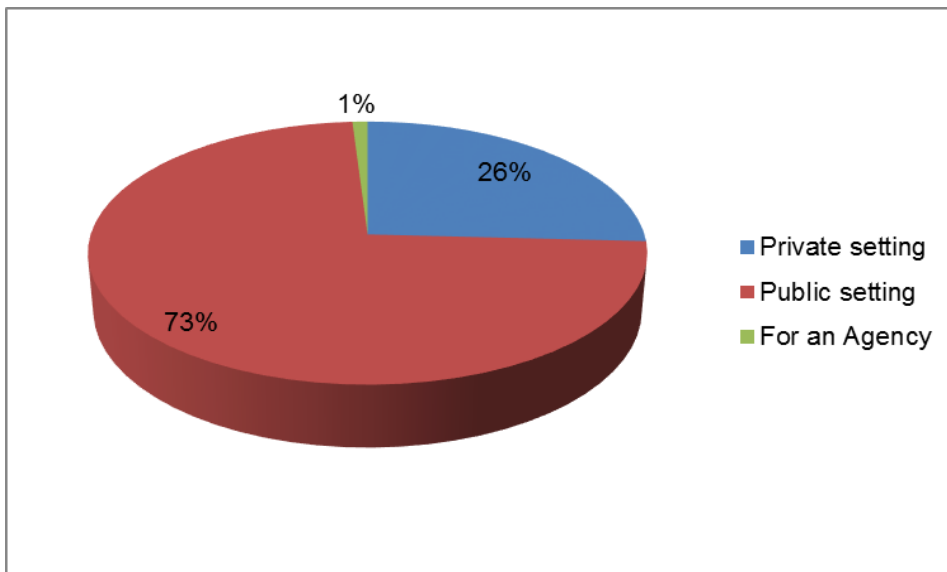
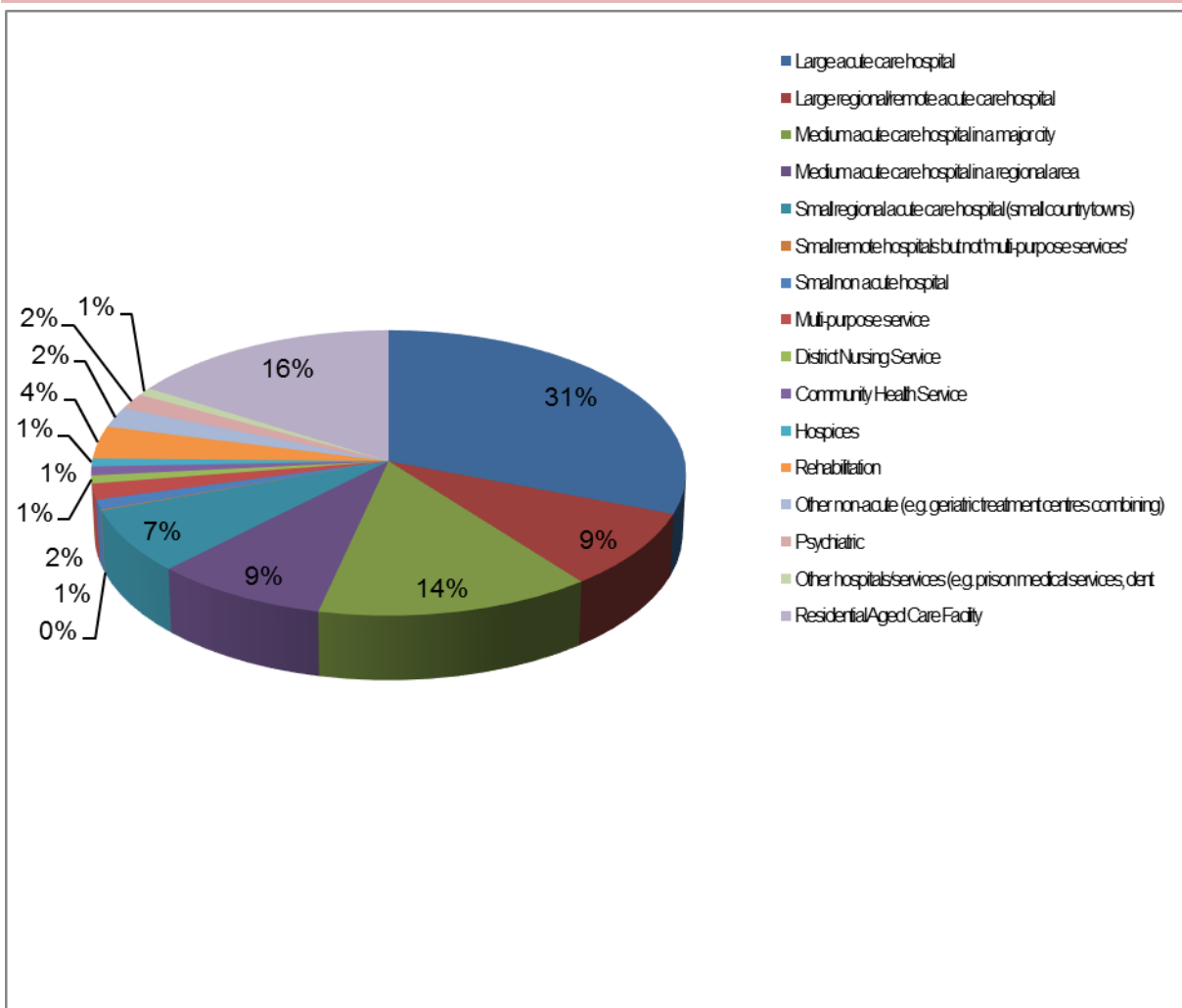


Figure 3.4: Workplace type of the respondent Victorian nurses/midwives



Just under nineteen percent of surveyed nursing staff are hospital trained with registered nurses making up thirteen percent of this number and enrolled nurses forming the remaining six percent. In Figure 3.5 it can be seen that a further twelve percent of respondents are qualified at Diploma level (enrolled and registered nurses at 8 percent and 4 percent respectively). Three quarters of all staff are qualified for clinical practice at degree level or above.

Figure 3.6 provides data on the origins of the nurses' qualifications. Predictably the majority trained in Australia, followed by the United Kingdom and New Zealand. A minor number of staff obtained nursing qualifications from countries where English would not have been used as their primary language. A similar distribution was obtained from candidates with midwifery qualifications. In all three studies to date we have examined the data to see if country of qualification impacts on missed care. To date, no evidence has emerged that this is a significant factor in the acute sector. Other researchers have found some evidence for this, although it is not conclusive (Xiao et al. 2014). In any case as can be seen, the majority of nurses qualifying overseas were in English speaking countries.

Figure 3.5: Nurse/Midwife qualifications of the Victorian respondents.

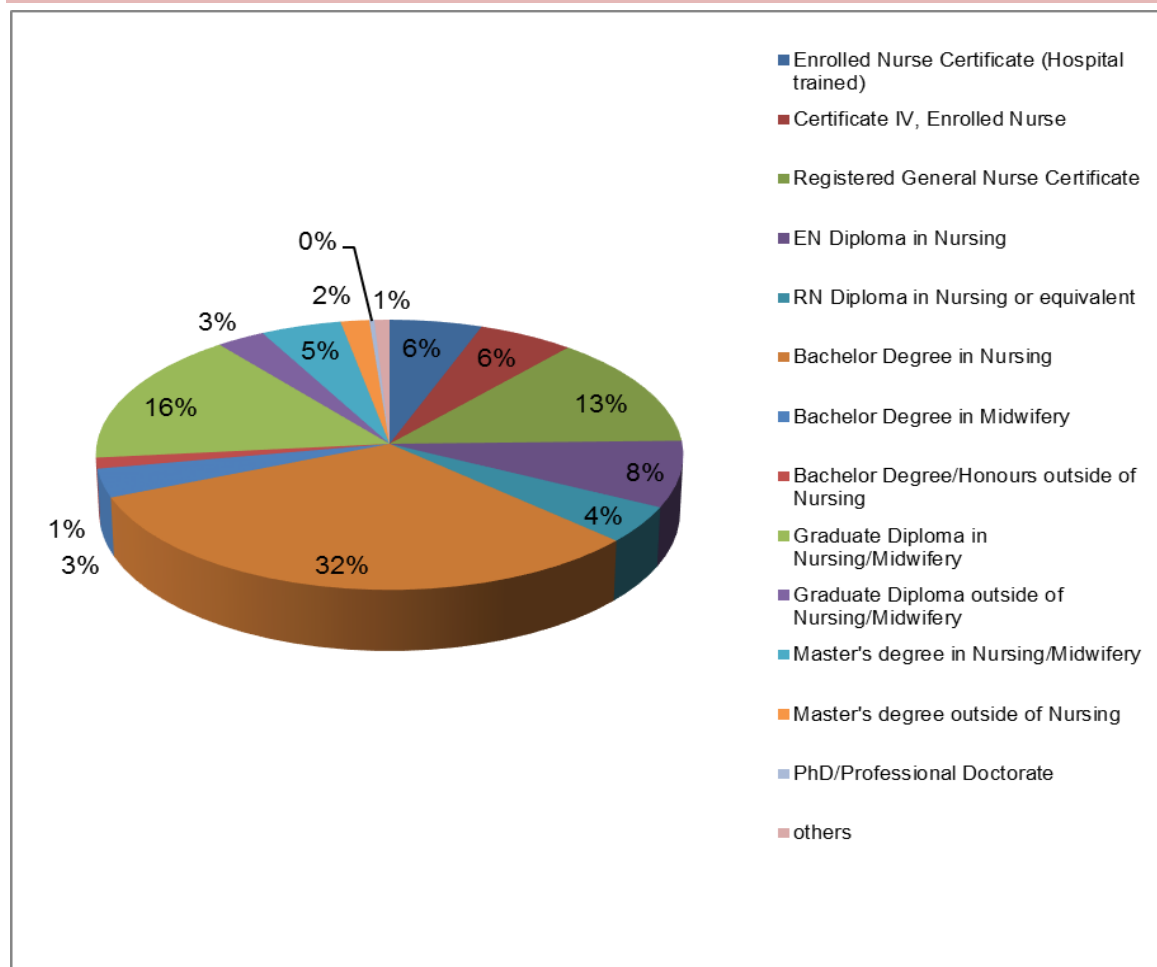
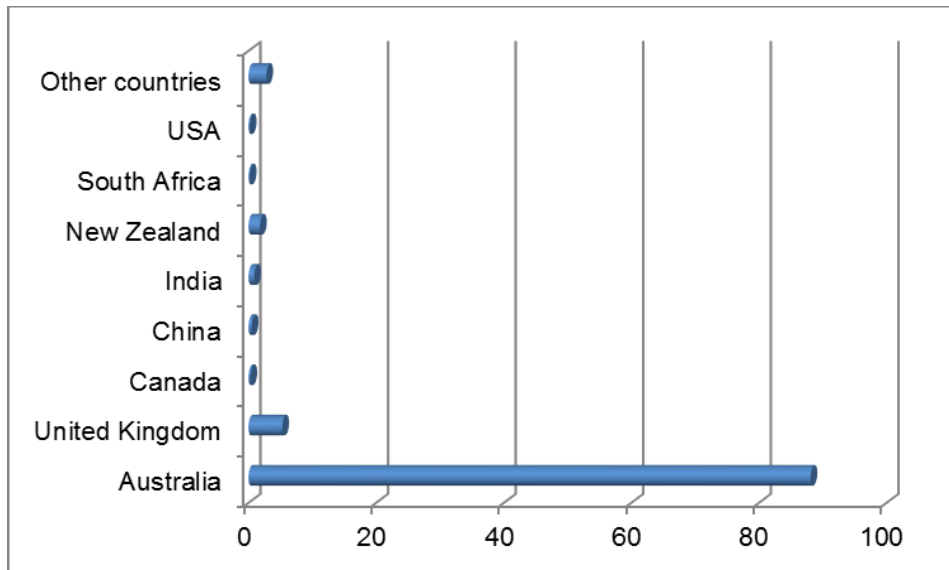


Figure 3.6: Origin of the Victorian Nurse/Midwife qualifications



Just less than three quarters of all survey nursing/midwifery staff were employed on a part-time basis (Figure 3.7). While the bulk of this group are employed on a permanent basis (67 percent) only twenty two percent of staff are employed permanently on a full-time basis. Staff employed as agency staff or on a fulltime casual basis or on part-time contract basis make up a very small number. These figures differ significantly from the cohort who completed the NSW MISSCARE survey. In that study, 48.23 percent of nurses worked full time with 44 percent part time. These figures for Victoria are consistent with research commissioned by the union around 7 years ago (Wise 2007) which showed that with increasing pressure to perform overtime nurses were opting for part time work; ie between 2003 and 2006 the number responding to the Workplace Research Centre survey as working part time went from 60 to 66 percent. As a consequence of the above numbers of part time staff, it is not surprising that one half of all staff are employed for 30 hours or more per week, while the remaining staff are either working less than 24 hours per week or between 25 to 30 hours per week (Figure 3.8).

Figure 3.7: Employment status of the Victorian Nurse/Midwives

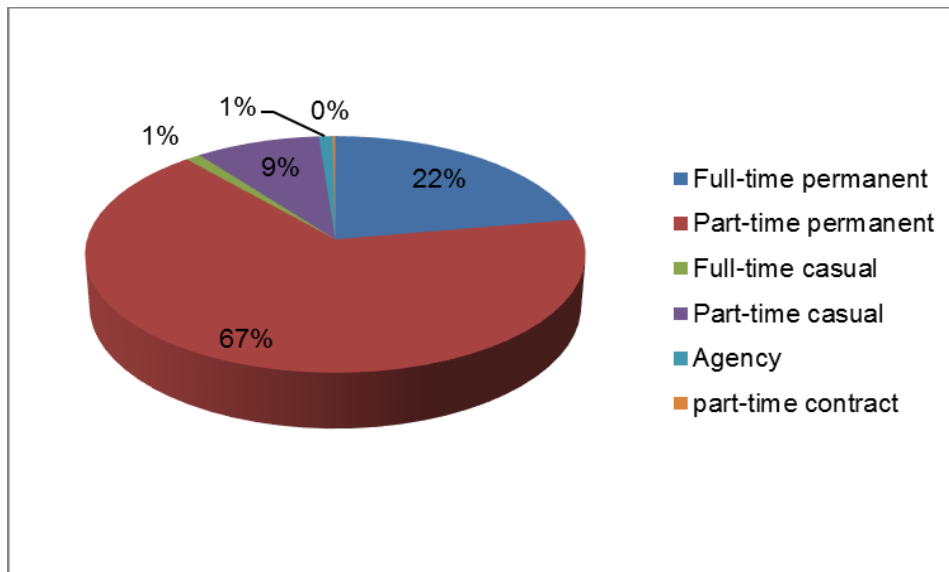
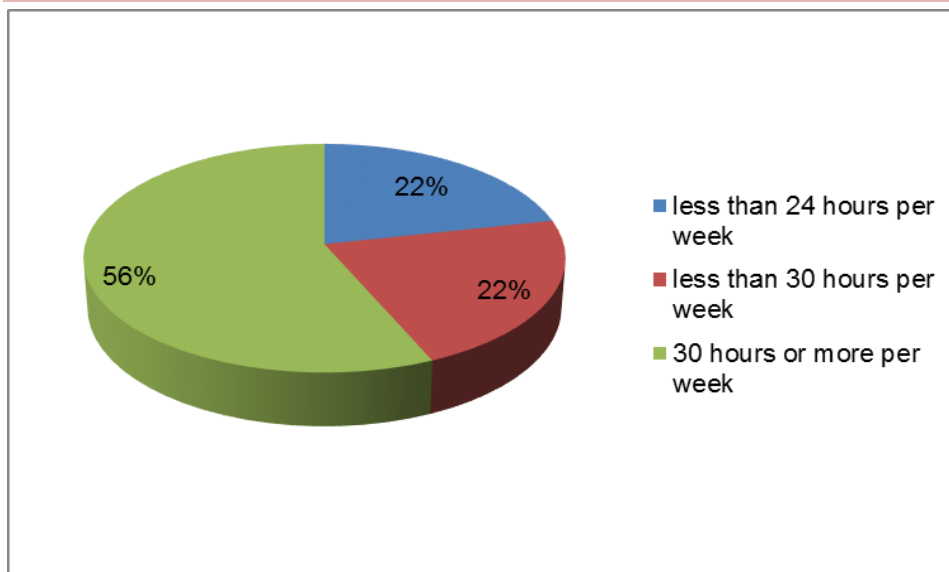


Figure 3.8: Employment hours of the Victorian Nurse/Midwives.



According to Figure 3.9, twenty-eight percent of all staff are on rotating roster/shifts (morning, afternoon, nights and weekends) with another sixteen per cent doing the same roster format precluding night shifts. Another eleven percent only work day shifts, with a sub group (9 percent) working just night shifts with a similar group only working weekdays (9 percent). Staff indicating that they work irregular shifts or who are on call constitute another sixteen percent (11 percent and 5 percent respectively). Figure 3.10 indicates that the majority of respondents prefer to maintain their current roster or work schedule with just over one third indicating a preference to change their current work schedule.

Figure 3.9: Usual working roster

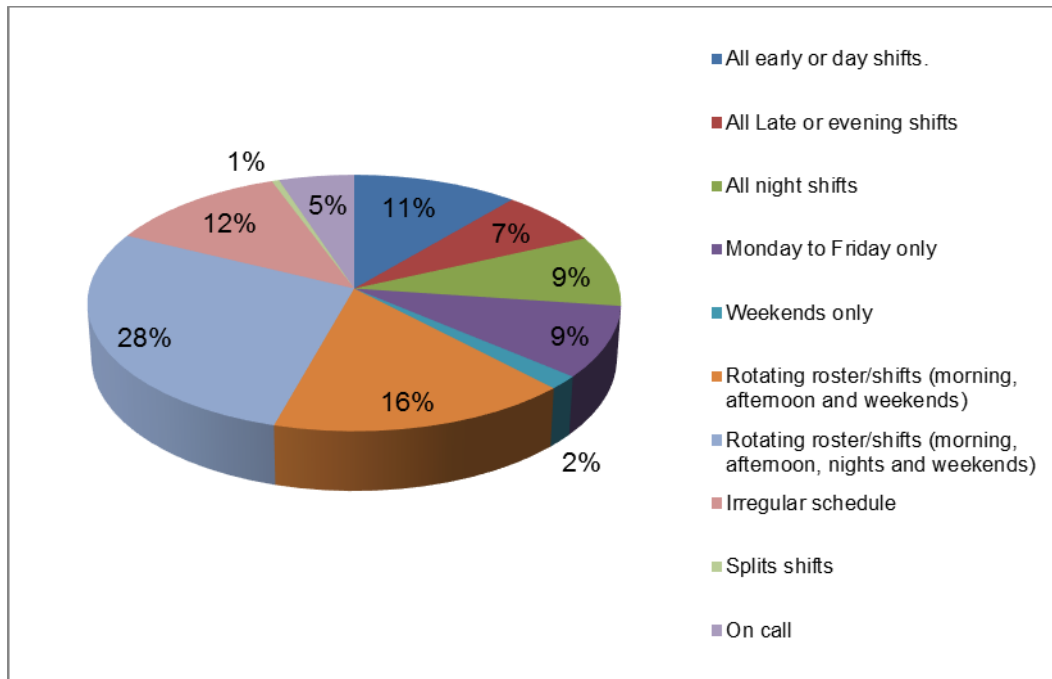
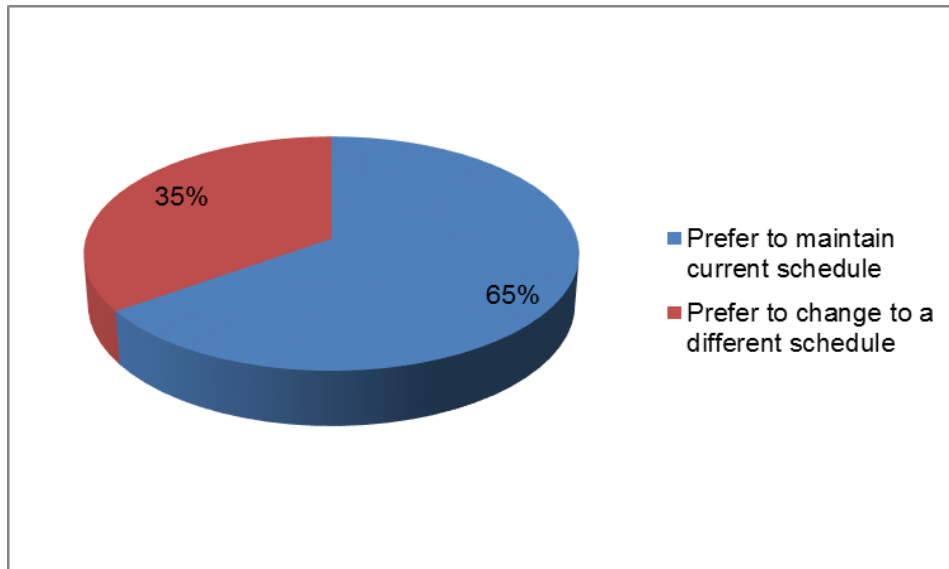
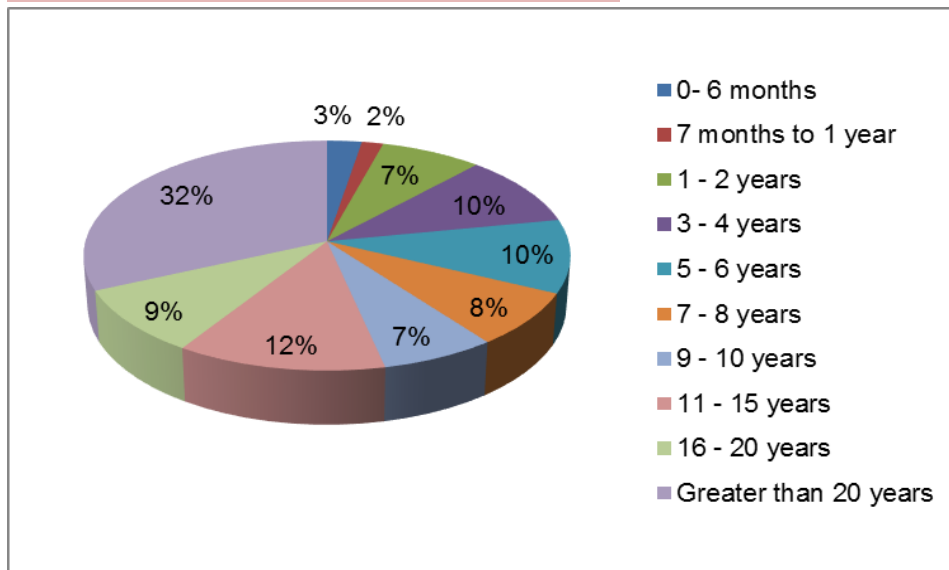


Figure 3.10: Victorian Nurses and Midwives roster preferences



Approximately one third of nurses had more than 20 years nursing experience while the median number of years of professional experience was between 11 to 15 years (Figure 3.11). Another twenty percent indicated work experience of between 3 to 6 years. Approximately seven percent of respondents indicated recent graduation with only one to two years of practice. This last figure is higher than NSW data of 3.63 percent, reflecting the increased need in Victoria to employ more nurses a result of overall population growth.

Figure 3.11: Length of professional experience



Working hours and work intensification

A key component of missed or rationed care is work intensification, or working overtime as a result of sudden acceleration in patient load or acuity, or working at a faster pace. Figure 3.12, demonstrates that only ten percent of all staff did not work longer than their rostered shift. Five to ten occasions was the most frequent response, followed by less than five occasions and conversely, more than twenty occasions over the past three months for 22 percent of respondents. Figure 3.13, provides data on the number of nurses claiming overtime in this period. As can be seen 28 percent of the respondents claimed overtime for five hours of less with another 18 percent claiming for up to 6 to 8 hours overtime. What is intriguing in these two tables is the number claiming to work overtime against the number who do not make a financial claim on the organisation (25 percent Table 3.13). Further, of the number of nurses who said they worked over 20 hours (22 percent), only 12 percent made a financial claim with 4 percent of total respondents indicating their claim was overturned by management.

Figure 3.12: Number of occasions when the Victorian Nurse/Midwives worked longer than their rostered shift (over the past three months)

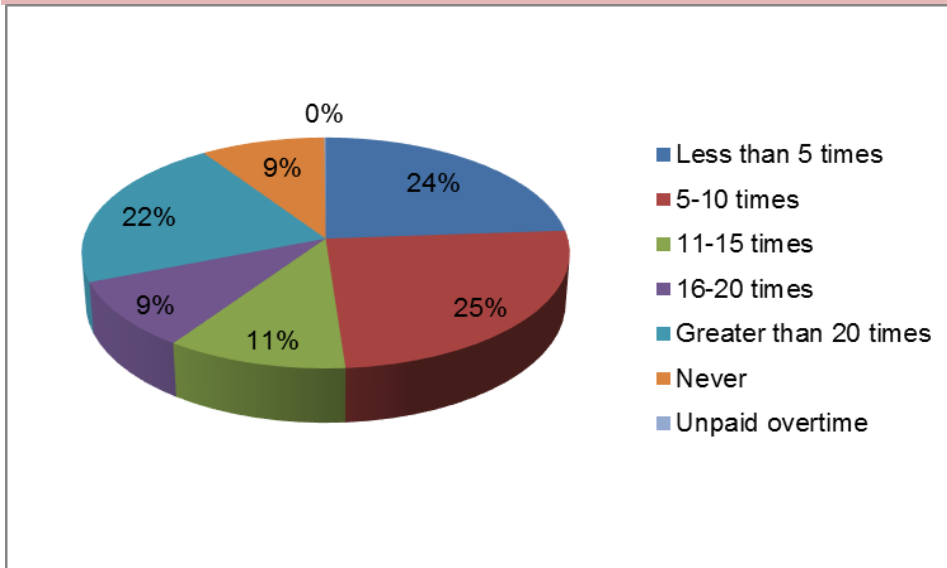
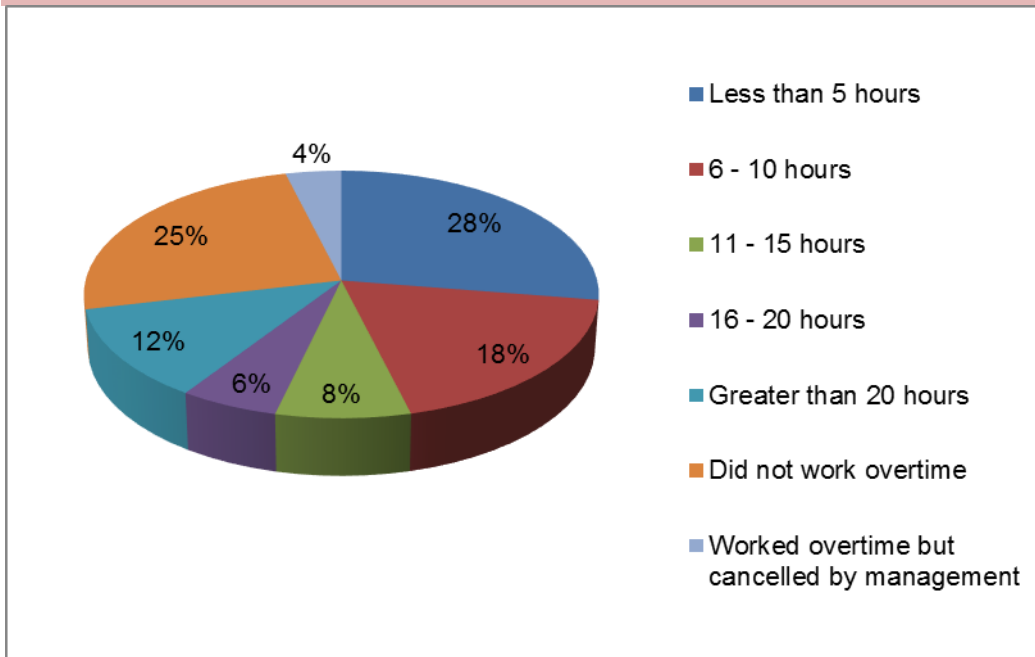


Figure 3.13: Hours of overtime claimed by the Victorian Nurse/Midwives (over the past three months)



Sickness and presenteeism and missed care

During the course of this research we have become aware of the number of nurses who present at work sick (presenteeism). In the Victorian survey, well over one third of all surveyed nurses had no time off within the past three months due to illness/fatigue. Of the remainder, approximately one quarter had either one shift or 2 to 3 shifts off. This is an interesting finding given the research by Dorrian et al. (2015) on the impact of shift work on

nurses' levels of fatigue. In their survey nurses reported that shift work, particularly night shift leads to higher levels of fatigue and illness. However, this may partly be explained by the data displayed in Figure 3.15 where 77 percent of nurses said they worked when sick. The reasons given are outlined in Figure 3.16. These can be divided into two broad categories; financial reasons (no leave left- 5 percent, I felt fit to work- 15 percent, financial reasons- 14 percent); and altruistic reasons (obligation to colleagues- 32 percent, and short staffed- 24 percent). The final category is other reasons at 10 percent. These figures suggest that 56 percent of staff go to work when sick in order to support colleagues and patients. Despite these alarming results the majority of nurses reported that their health was Excellent to Good (92 percent) with only 8 percent reporting Fair to Poor health (Figure 3.17).

Figure 3.14: Number of shifts not worked by Victorian nurses/midwives due to sickness, injury and/or significantly fatigued (over the past three months)

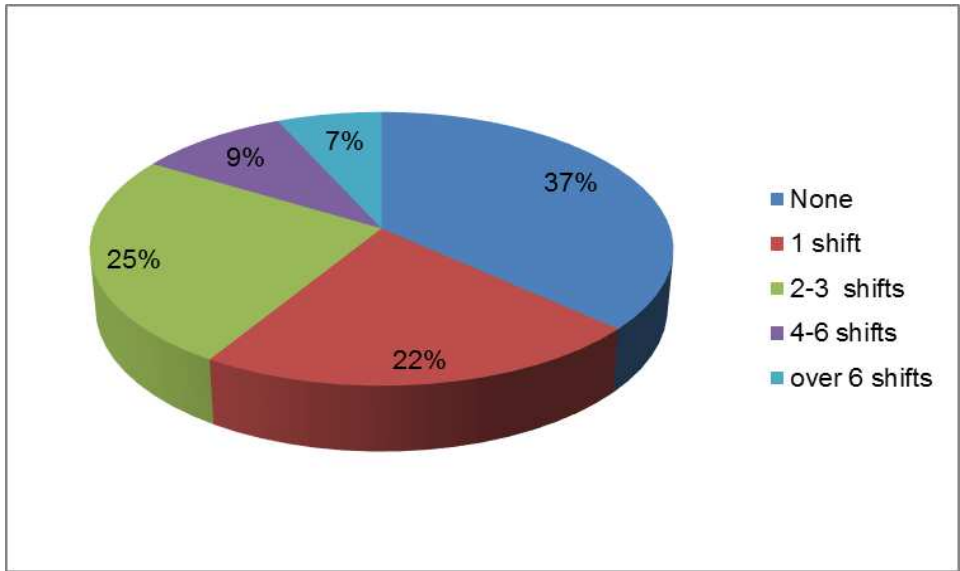


Figure 3.15: (Question 23): Number of shifts you worked even though you were sick, injured or significantly fatigued

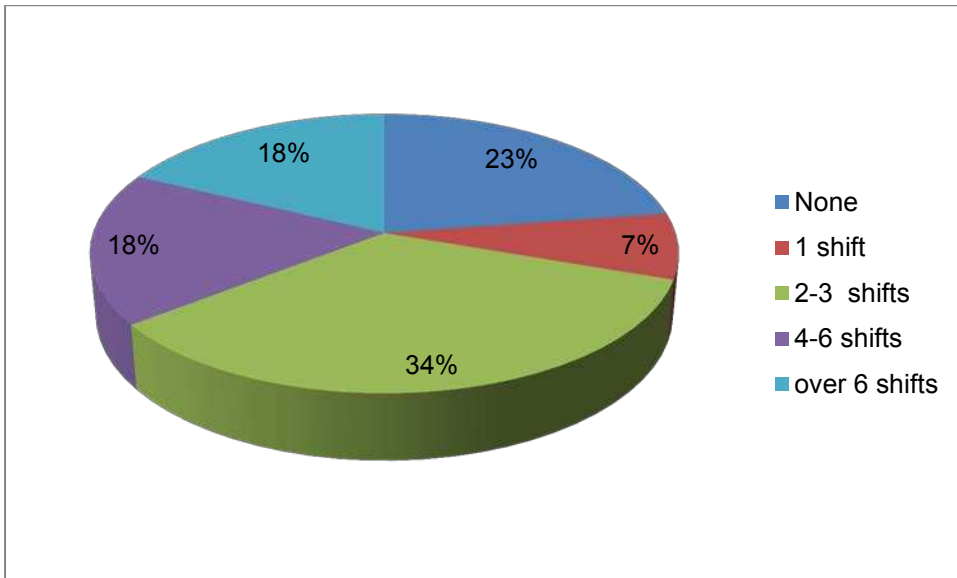


Figure 3.16: (Question-24): Causes of working while sick, injured or significantly fatigued

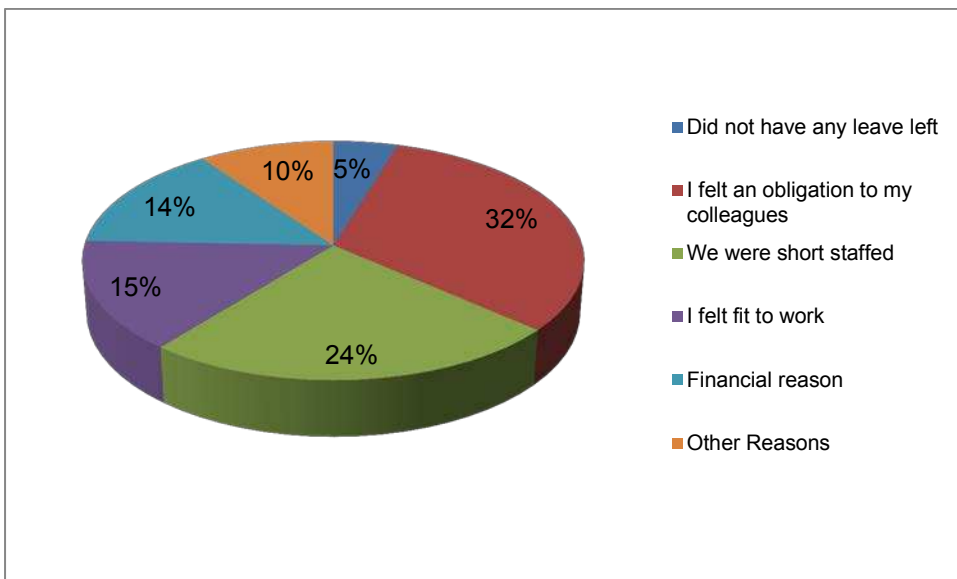
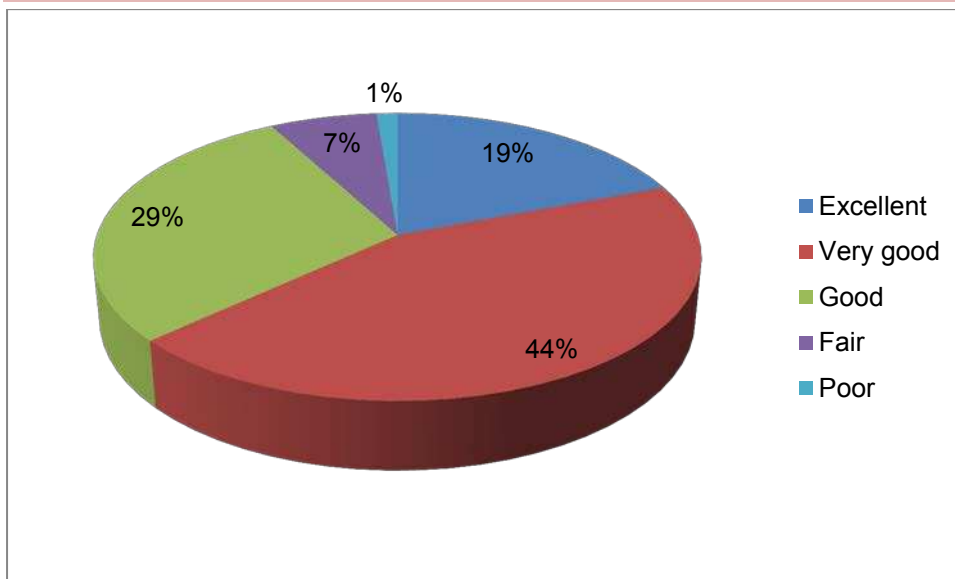


Figure 3.17: (Question – 25): Status of health of the respondents



Adequacy of staffing levels

The number of nurses who said staffing was adequate 100 percent of the time was 6 percent with 47 percent indicating it was adequate 75 percent of the time and a further 27 percent indicating it was adequate 50 percent of the time. This data suggests that staffing levels are subject to changes in patient load and acuity. This is certainly consistent with findings from other research on missed care where nurses claim workload fluctuates when there is a sudden influx of patients, a patient becomes seriously ill, or resources are not available (Blackman et al. 2015a). It would appear that the mandated staffing ratio caters for the normal situation at least 50 percent of the time. A further 47 percent indicated that staffing was inadequate between 50 percent and 100 percent of the time (Figure 3.18). Consistent with the profile of survey participants and the nurse-patient ratios in Victorian public hospitals the majority of nurses cared for less than 9 patients (73 percent) per shift (Figure 3.19). A further 12 percent cared for 10-19 patients per shift while the remainder cared for 20 to over 80. Analysis of this data would assume these nurses and AiNs work in the aged care sector. As indicated in Figure 3.20, 36 percent of nurses indicated their organisation used a staffing tool. Qualitative comments for this question indicated that the tool was the nurse-patient ratios that form part of the EB Award, or other tools such as Kronos, and Trendcare. However, the majority were not sure. According to Gerdtz and Nelson (2007) Trendcare is used in over 80 hospitals in Australia and it is the most widely used system in Victoria.

In Figure 3.21 the question asked whether or not the staffing tool prevented situations of missed care. The results here are difficult to determine as 57 percent of respondents did not provide an answer. Seven percent answered in the affirmative, 27 percent said NO, and 9 percent were unsure. Previous studies investigating missed care indicate that nurses are not aware of how staffing levels on their ward are determined (Blackman et al. 2015a).

One of the keys to missed care is sudden influxes of patient admissions. As a consequence we asked nurses to detail the number of patient admissions during the shift. Predictably over 86 percent had less than 5 patients per shift, with 8 percent claiming around 6 to 10 patients per shift. The remaining 6 percent provide numbers between 11 and 25 suggesting these may well be nurses working in accident and emergency departments (See Figure 3.22).

Figure 3.18: (Question – 26): Adequacy of staffing on unit

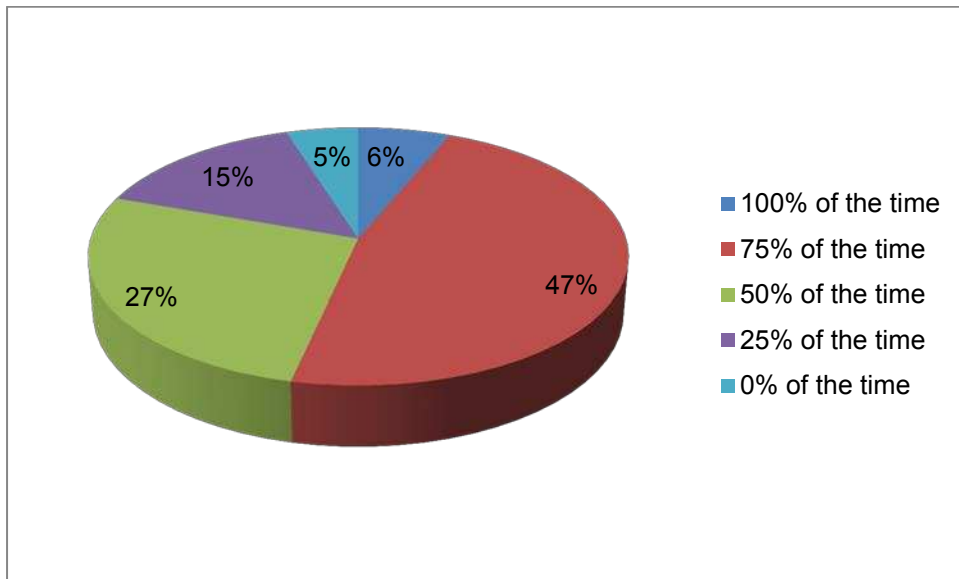


Figure 3.19: (Question 27): Number of patients you care for

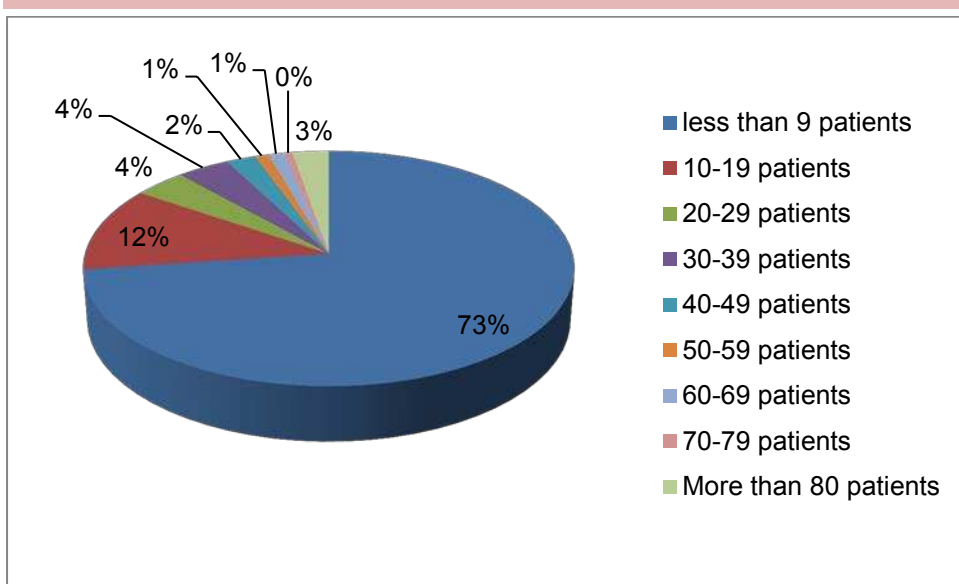


Figure 3.20: (Question 28): Does your organisation use a staffing tool

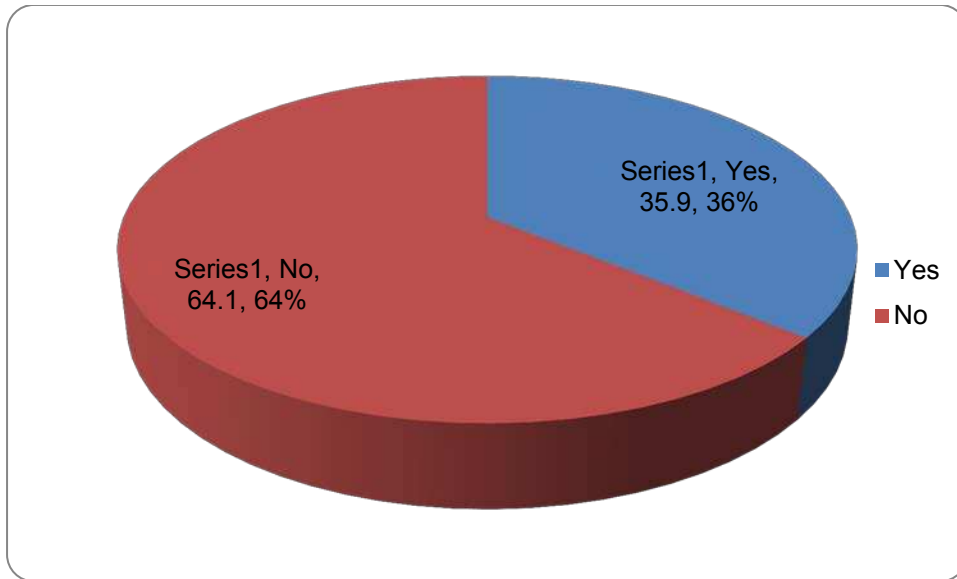


Figure 3.21: (Question 29): Does the staffing tool used in your organisation assist in preventing missed nursing care

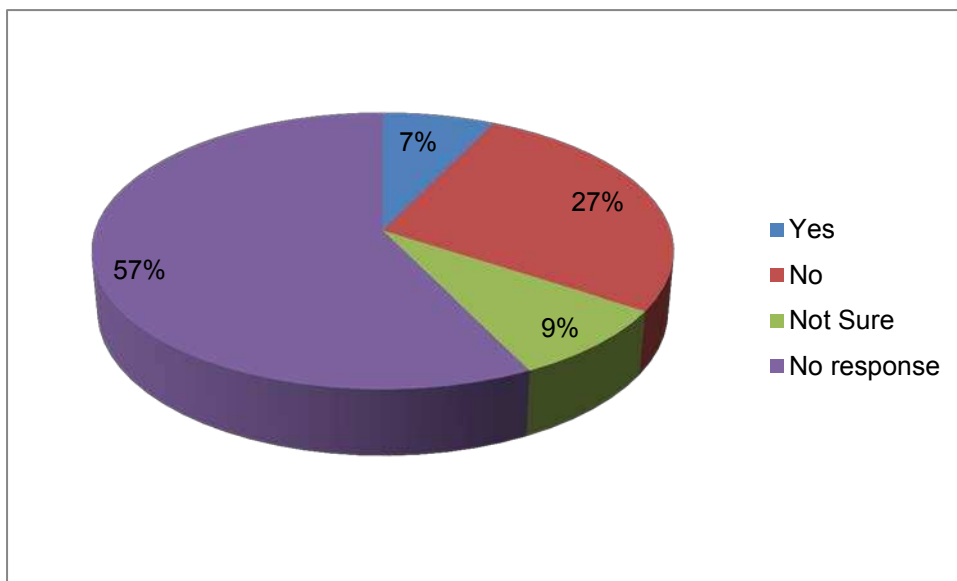


Figure 3.22: (Question – 30): How many patients admission did you have?

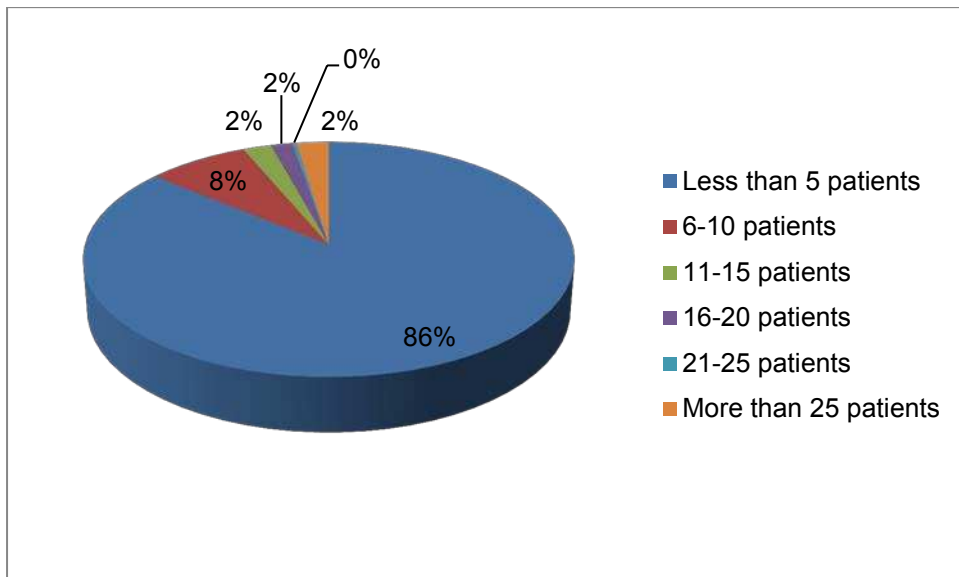
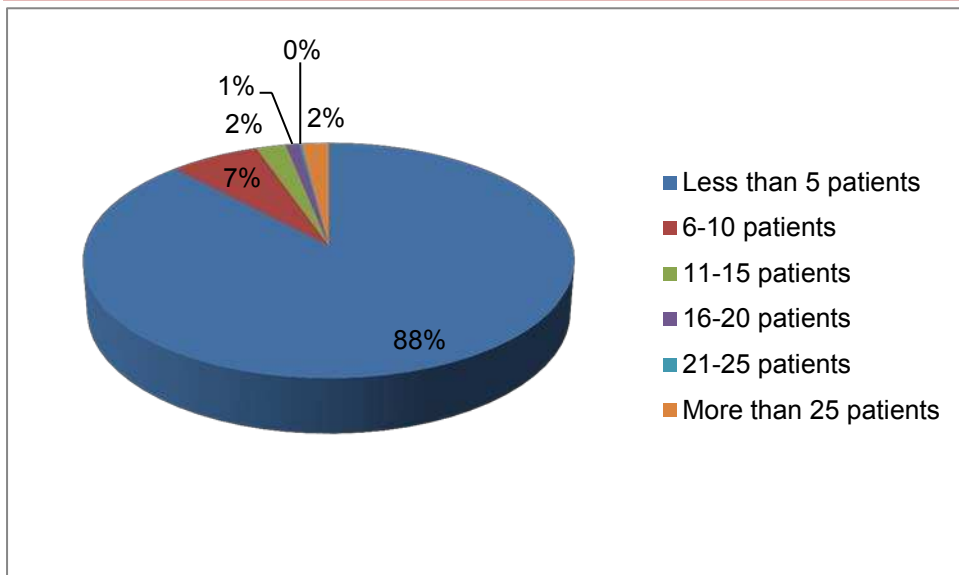


Figure 3.23: (Question – 31): How many patients discharge you have?



Employee satisfaction with their work and working team

It might be assumed that nurses would have a high level of dissatisfaction with their working conditions. Indeed the research by the AWRPS conducted in 2012 under the auspices of the union suggests that nurses are not as satisfied with their working conditions as other workers (Holland et al. 2012). The Holland study allowed for international comparisons and indicated that on 6 items nurses rated their profession lower than other occupational groups. One of these items included intention to leave the profession with over 15 percent of nurses indicating this was so, as against 4 percent of other workers. The findings from the two MISSCARE surveys conducted in Australia to date are contrary to these finding indicating that nurses are satisfied with their current position (13 percent very satisfied, 54

percent satisfied) with 33 percent either dissatisfied or very dissatisfied (Figure 3. 24) (Henderson et al. 2013; Blackman et al. 2015a). As highlighted in Figure 3.25, 64 percent of the respondents had no intention of leaving the profession, 14 percent planned to do so in the next 6 months with a further 20 percent intending to do so within the next 2 to 3 years. Figure 3.26 illustrates that 51 percent of the respondents were satisfied with being a nurse, with a further 36 percent very satisfied. This is high percentage of 87 percent of nurses and midwives satisfied with their profession.

Figure 3.24: (Question – 32): Satisfaction with your current position

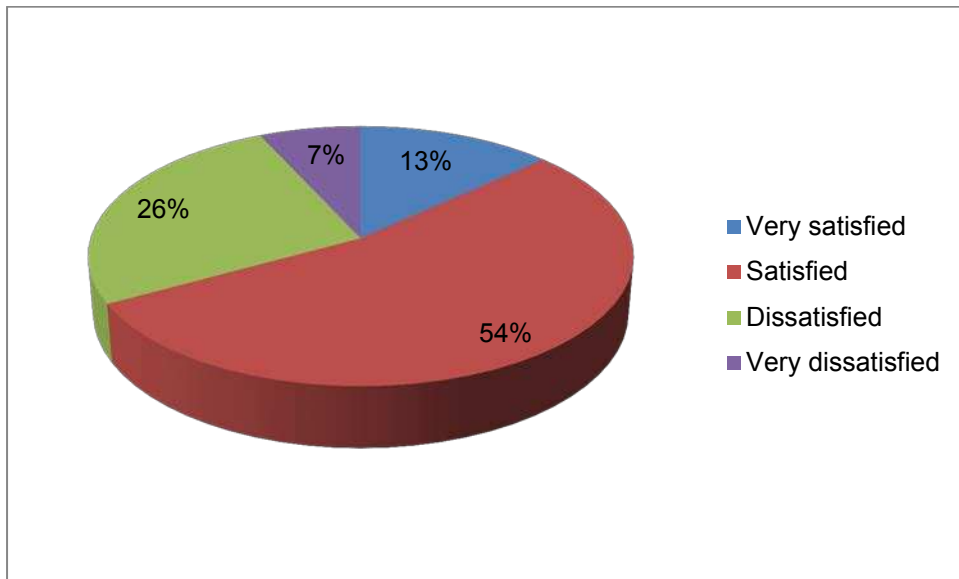


Figure 3.25: (Question 34): Plan to leave your current position

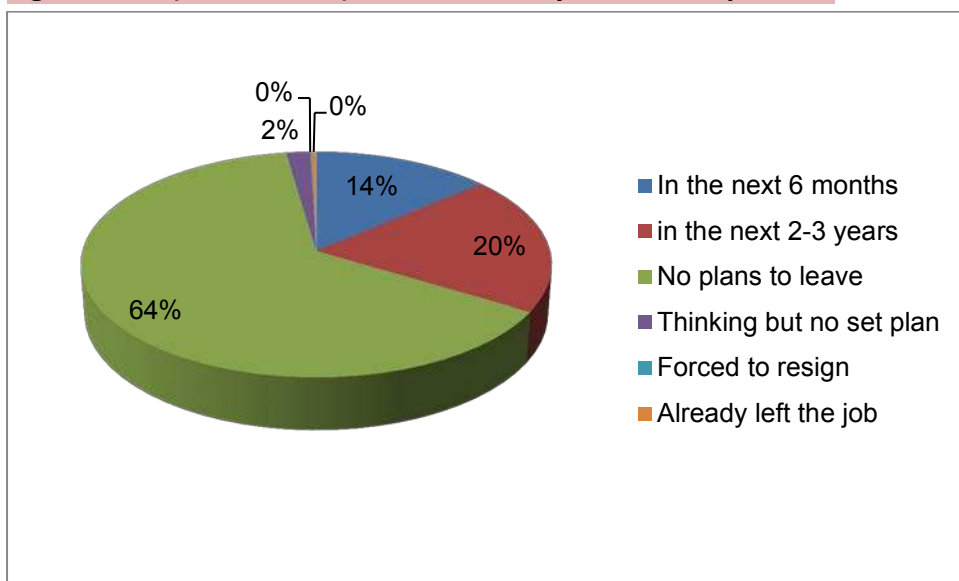
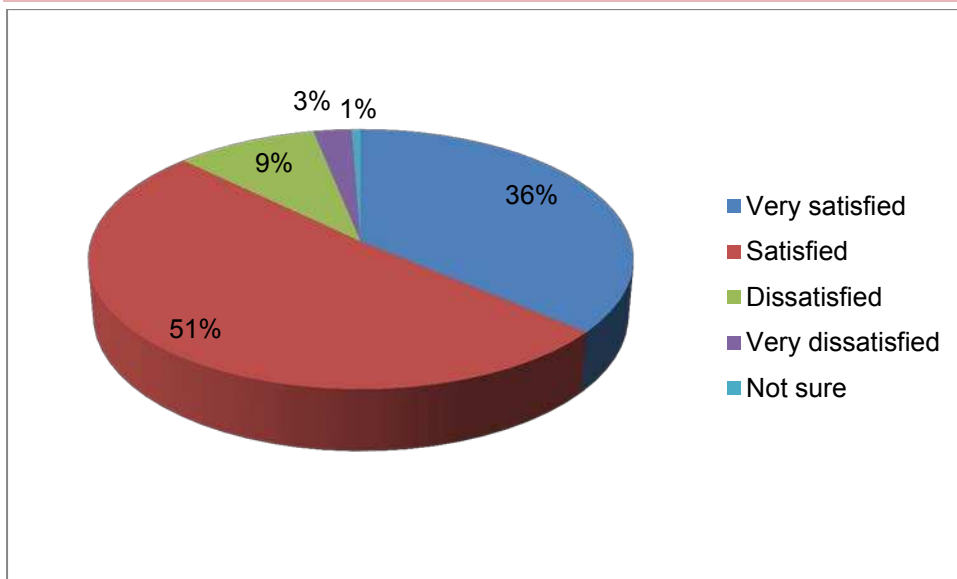


Figure 3.26: (Question 35): Satisfaction as a nurse/midwife



Managerial responses to missed care: Rounding

One of the major managerial responses to missed care has to been to instigate rounding (Willis et al. 2015). Rounding as a managerial process formally standardises nurse rounds to check on patient well-being and vital signs. Experienced nurses would perform patient rounds as a matter of course, however, with increased patient acuity and work intensification it is possible that some care is rationalised and as a consequence care items may be missed. As noted in figure 3.27 approximately 53 percent of nurses reported that rounding was part of their daily work. In the qualitative comments where we asked the respondents to tell us how they understood 'rounding' a number of nurses reported that they did not understand the question, or wondered why we asked it, given that monitoring their patients was core to nursing care. More importantly, they also noted that given that they engaged in bed-to-bed handover, and worked in close proximity to patients such a standardised practice was not required. While over 1000 nurses elaborated on this question, a number also noted that rounding would not be appropriate in their context. This included nurses working in Accident and Emergency departments, ICU, and in community settings. It is also true that some nurses saw rounding as a way to ensure all patients got some level of care. This appears to be one of the strategies applied in residential aged care. As can be seen from Figure 3.28 the majority of rounds are done hourly and as Figure 3.29 illustrates, it is inadequately recorded. This last figure is consistent with a qualitative study done by Willis et al. (2015) where nurses from one large tertiary hospital in South Australia indicated they misunderstood the legal status of recording their rounding observations. Some thought it was a legal document, while others were irritated that it was not part of the official documentation, and others admitted to fudging the records. As Figure 3.29 demonstrates 65 percent reported that they do not document their rounds.

Figure 3.27: (Question 36): Do you do 'rounding' as part of your work?

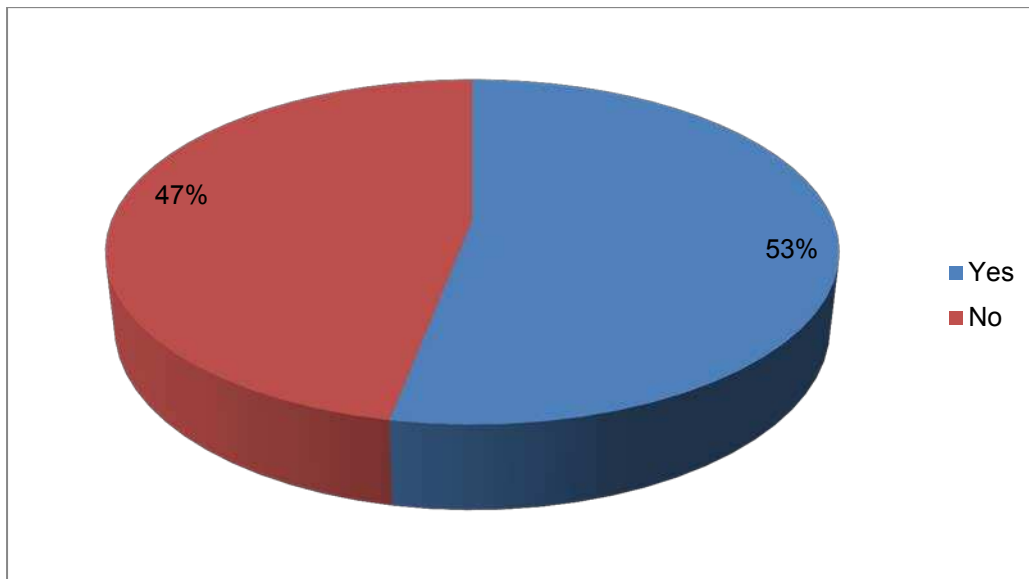


Figure 3.28: (Question 38): How frequently that your workplace expects you to conduct rounds.

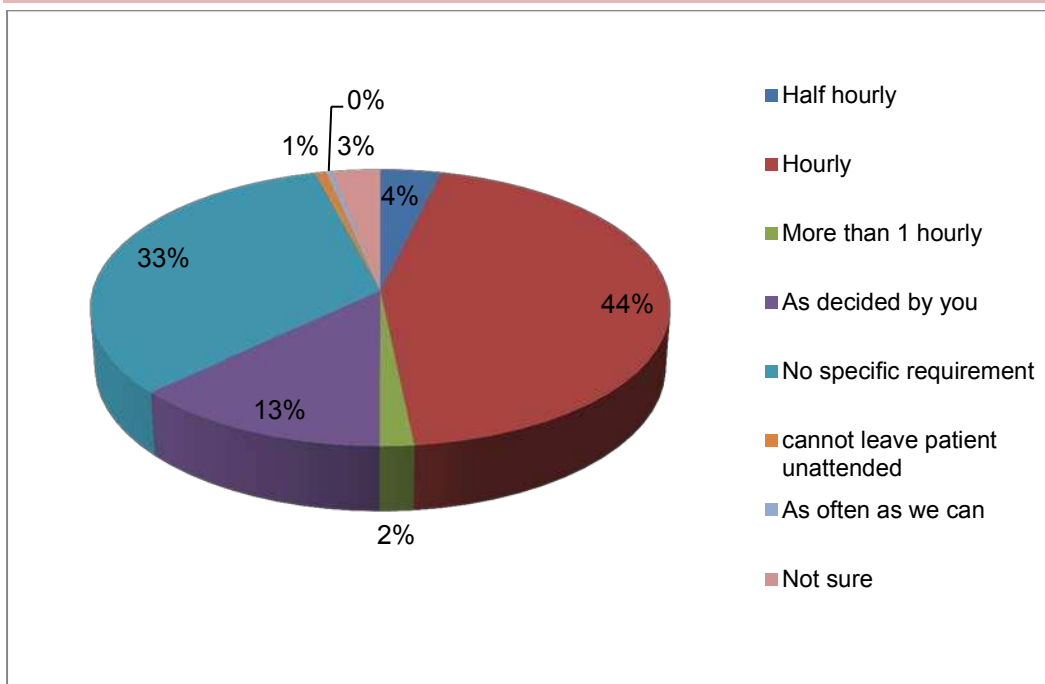
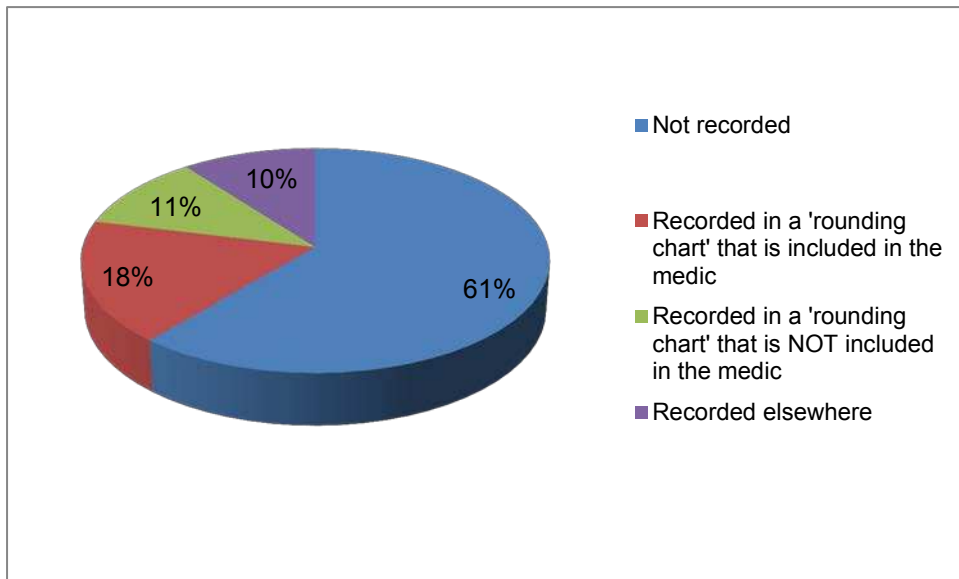


Figure 3.29: (Question 39): How is rounding recorded in your workplace?



Missed care: Nurses accounting for missed care

Having established the general nursing environment participants were then asked to indicate what care tasks they thought were most often missed on all three shifts. Table 3.1 provides the outcomes of this question while Table 3.2 lists the major reasons care is missed. The scale used to measure the directions and intensity of all of these reasons consists of five options that ranged from not a reason, to a minor, moderate or significant reason.

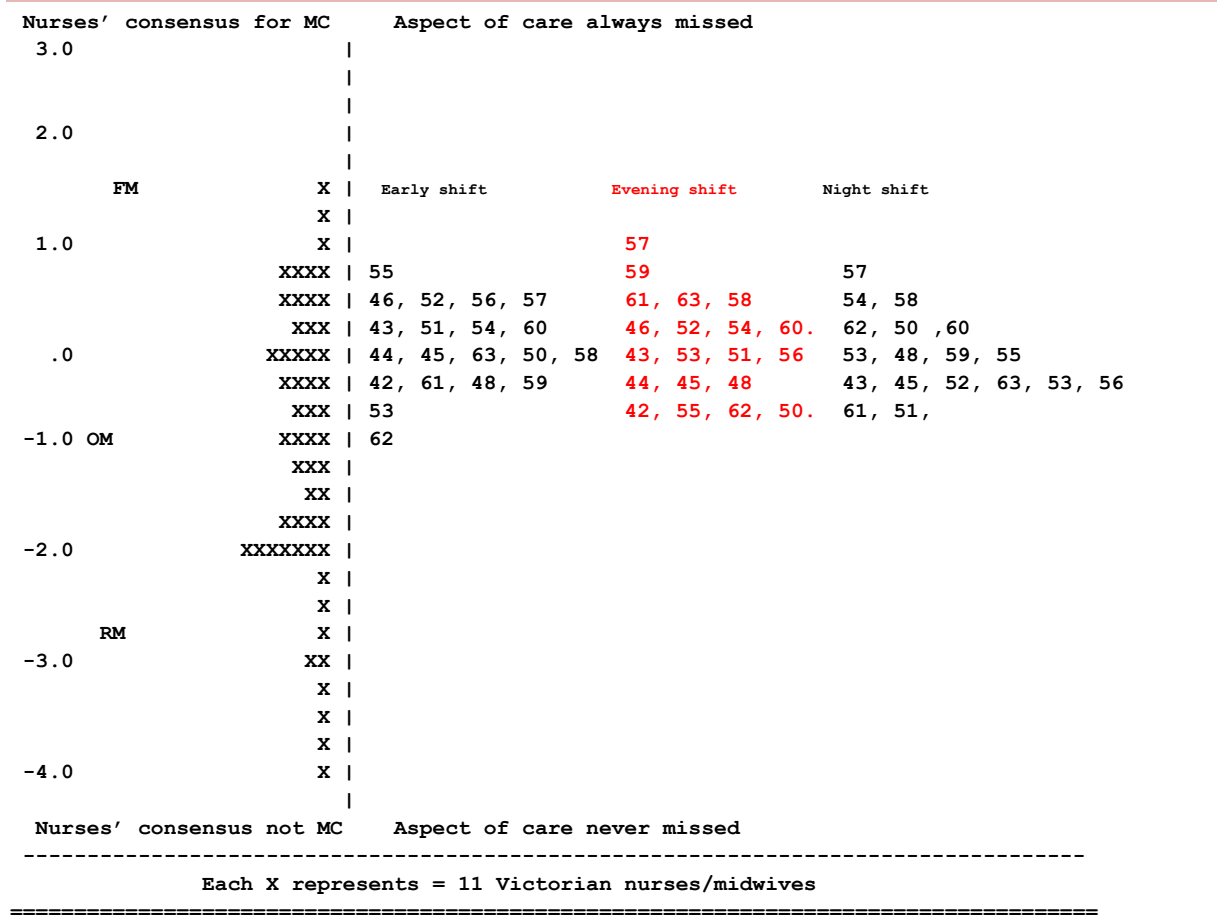
Table 3.1: (Questions 42 – 63): Comparative mean scores for frequency in which care is missed across all shifts

	Early/ Day	Late/ Evening	Night
Assist in ambulating three times a day or as ordered	3.4683	3.4607	3.7985
Turning patient every 2 to 4 hours	2.8089	2.7900	2.6982
Feeding patients while food is still warm	2.8694	2.8486	2.8581
Assist with toileting needs within 5 minutes of request	2.9707	2.9432	2.8325
Setting up meals for patients who feed themselves	2.2952	2.2829	2.0719

Vital signs taken as ordered	2.5090	2.5090	2.5090
Monitoring intake/output as ordered	2.8789	2.8704	2.6689
Full documentation of all necessary nursing/midwifery interventions	2.7616	2.7616	2.7616
Patient education about illness, tests and diagnostic studies	2.7748	2.7956	2.8477
Emotional support to patient and/or family	2.4683	2.4210	2.3113
Patient Hygiene	2.3169	2.3642	2.2535
Patient Oral Hygiene	3.0208	3.0407	2.9585
Nurse Hand Hygiene	2.1088	2.1107	2.0624
Skin/Wound Care	2.3132	2.2715	2.2148
Patient discharge planning and education	2.2980	2.3226	2.2583
Bedside glucose monitoring as ordered	1.9801	1.9735	1.9347
Focused reassessments according to patient condition	2.2488	2.2403	2.1949
IV access devices and assessments according to hospital policy	2.2365	2.2346	2.2318
Response to call bell/light initiated within 5 minutes	2.8411	2.8316	2.7058
PRN medication requests acted on within 15 minutes	2.2592	2.2375	2.1552
Medications administered within 30 minutes before or after scheduled time	2.5393	2.5024	2.3434
Assess effectiveness of medications	2.4853	2.4484	2.3765

From Figure 3.30, it can be seen that all the missed care items across all three shifts are co-located on the same linear scale, to compare the distributions of the frequency and types of missed care across the twenty-four hour period.

Figure 3.30: Frequency and type of Missed care across the three shifts



To the left of the vertical linear scale are a series of Xs (each representing the response of 13 nurses) and they are positioned at the top of the scale (at +1.5 to - 4.0 logits) graduating down to the lowest end of the scale. This distribution of nurses/midwives' responses indicates the level or intensity of agreement or consensus as to how frequently care is missed. Participants located at the top of the scale indicate most strongly, that care is missed most frequently with respondents indicating less frequency of missed care, the further down the linear scale each participant is located.

From Figure 3.30, it can be seen that participants indicate a broad range of beliefs about the frequency of missed care as the scores are spread across the scale. The bulk of staff indicated that the survey items of care are occasionally to frequently missed. This can be seen by the series of X's that occur on the logit scale at -2.0 to +1.0 with the latter score indicating a belief that that care is missed more frequently. To the right of the central vertical linear scale in Figure 3.30, are the individual items of missed care and their position on the linear scale indicates to what extent this aspect of care is believed to be missed. These estimates are co-located on the same linear scale as the staffs' estimates of the frequency with which the missed care exists. Missed care survey items are positioned on the logit scale ranging from -1.0 to +1.0 logits. Missed care items located closest to the top of (at

+1.0 logits) on the linear scale indicate that this aspect of care is more frequently missed. Items located progressively down the scale confirm decreasing frequency in this aspect of care being missed.

It can be seen in Figure 3.30, all the missed care items for all three shifts have been co-located for comparison. Firstly it is worth noting that all the surveyed missed care items (across all three shifts) are mostly confined to a very narrow range extending from approximately -1.0 to +1.0 logits. This indicates that the types and frequencies of missed care are understood by Victorian nurses and midwives to not deviate significantly from each other in terms of their frequency in being omitted within a shift and across all three shifts.

Missed care estimates within the same shift

Turning attention to the day shift missed care items, it can be seen that item 55 (Skin/wound care) is missed the most frequently during the day shift whereas the prompt administration of medications is missed least frequently (item 62) during the day. Looking at the afternoon shifts, it is clear that item 57 (bedside glucose monitoring) is missed most frequently during that shift, whereas several aspects of care (item 42: Turning patients, item 55: oral hygiene, item 62: prompt medication administration and item 50: patient education) are thought to be missed least of all. The night duty estimates are also shown in Figure 3.30 and it should be noted that three missed care items have been deliberately omitted from the group. Items 42, 44 and 46 (representing patient ambulation, feeding and sitting the patient up for meals while in bed) were not seen as being appropriate night shift care (confirmed by them showing poor reliability indices for these three items) and were therefore removed from any further analysis. The remaining missed care items suggest also there is some diversity in the ranges of care activities that are omitted or not, even for night duty staff. Items 61 and 53 (providing prompt PRN medication and providing emotional support to patient/family respectively) are located approximately at logit -1.0, indicating that these aspects of care are least missed on night duty, whereas items 57 and 58 (monitoring BSL and assessing patients respectively) are listed as being not done frequently, possibly due the fact that patients are usually asleep at this time.

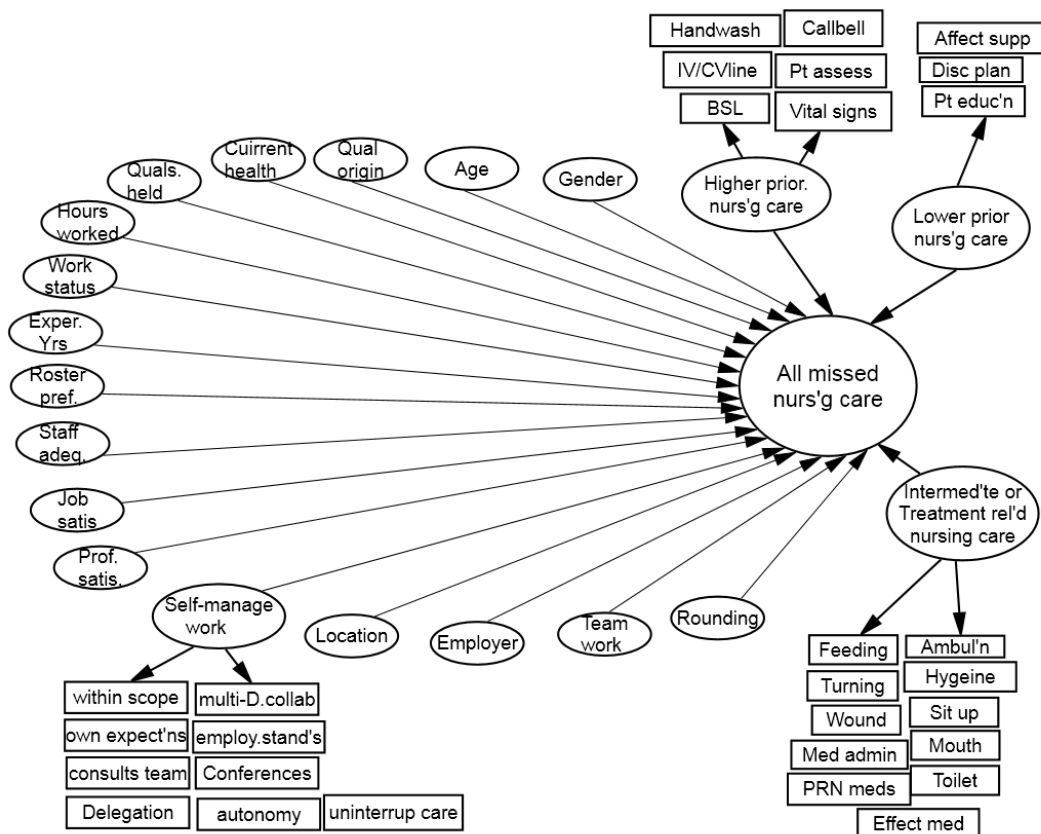
Missed care estimates across the different shifts.

Figure 3.30 also illustrated that variations between the same missed care items can be tracked across the three different shifts. The most significant changes occur to several items. Item 59 (managing parenteral devices) are seen to be missed more often during the evening shift compared to the morning shifts (noted change on logit scale from -.05 to +0.5 from am to pm shift time in Figure 3.30). Item 55 (Skin and wound care) is missed most of all during day shift, but is one of the aspects of care that is missed least of all, by staff on evening shifts. Afternoon staff are more likely to miss providing prompt PRN medications (item 61) compared to the morning staff and similarly with following up if the medication given was in fact, effective or not (item 63).

Predicting factors that influence the types of care being missed and their frequency of being missed

Exploring the diversity and variance of the participants' scores for missed care provides evidence in predicting what aspects of care are missed particularly if the factors/variables which are thought to impact on the missed care scores are concurrently taken into consideration. Figure 3.31 represents this relationship for the frequencies of missed care. From the diagram, it can be seen that nineteen factors/variables are thought to have a direct impact on the frequency of missed care. They include Individual nurse/midwife demographic factors, variables depicting different aspects of the employment environments and lastly the major groupings of missed care. The intensity of influence each variable will have on the final missed care scores can be determined statistically by the nurse/midwives' responses to the survey and serves as the basis for predicting missed care. The various care tasks are divided into three categories following Alfaro-Lefevre's (2008) model of Higher, Lower and Intermediate level nursing tasks.

Figure 3.31: Conceptual model predicting frequencies and types of missed care



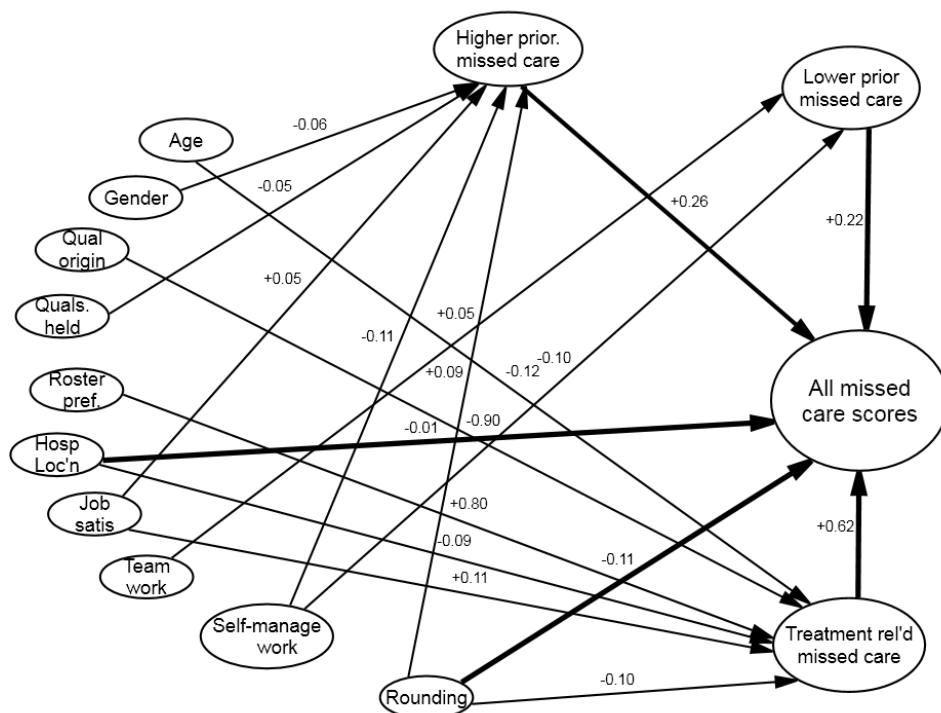
Predicting missed care across the three shifts

There are both commonalities and variations in the factors that influence missed care across the three different shifts. Figure 3.32 highlights both the direct and indirect factors that impact on the type and frequency of missed care for night duty staff

Accounting for variance in night shift missed care scores

Before exploring those factors which do have an impact on missed care during the night shift, it is worth highlighting those factors/variables that were shown NOT to have any statistically significant impact at all on missed care during the night shifts. Participant demographic factors which can be negated included the staffs' self-rated *level of their current health*, the *number of hours they were employed* per week, whether they were *employed on a part or fulltime basis* and their overall satisfaction with being a *member of the nursing/midwifery profession*. A factor derived from within the structure of the organisation/employer which had no impact on night shift missed care was the type of health care agency where the individual staff member was employed - *private of public agency*.

Figure 3.32: Factors impacting on the type and frequency of missed care (night shifts)



Overall missed care is strongly defined by the type of care that is missed. With co-efficients of +0.62, +0.26 and +0.22, it can be seen that treatment related care is missed most often, followed by lower priority care and then higher priority care respectively. Missed care on

night shifts is also more likely to be missed in the rural sector health care agencies (-0.01) and when rounding is used (-0.11).

As treatment-related nursing care is the most likely form of care to be missed, it is important to note that this factor in turn is further influenced by other variables, namely the older age of the nurse/midwife (-0.12), dissatisfaction the staff member has in their current job (+0.11), the use of rounding practices (-0.10), where the nurse/midwife obtained their original qualifications (-0.90), the worksite location (-0.09) and lastly staff satisfaction with their current rosters (+0.80). Collectively these variables indicate that missed treatment-related care is mostly likely to be identified by older staff members who qualified elsewhere other than in Australia, who are employed in the rural sector and where rounding practices are used.

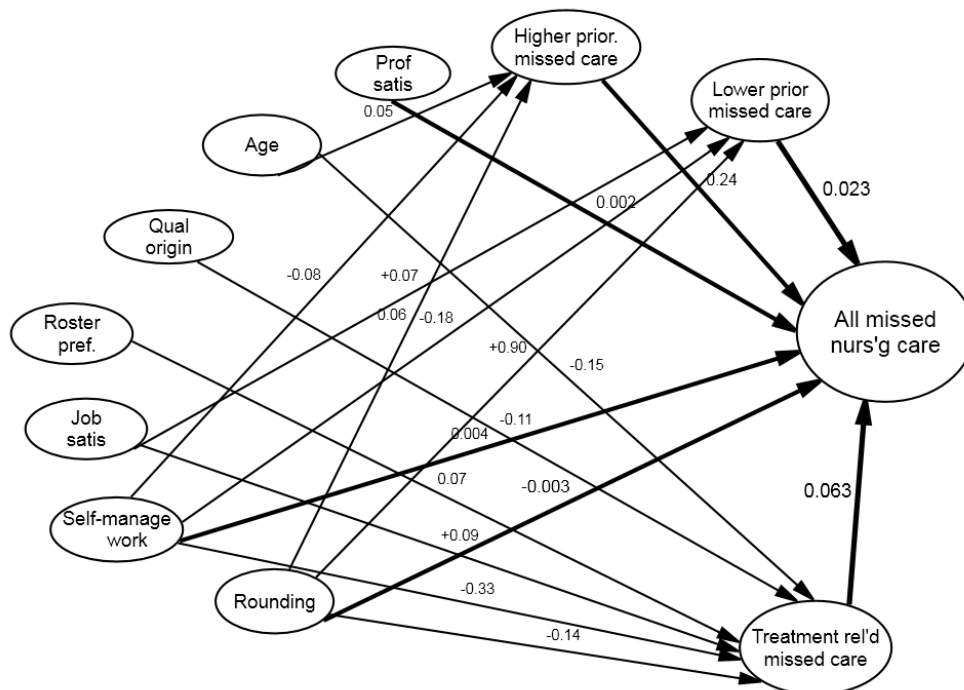
Missed lower priority care is also a significant influence on the frequency and type of overall missed care administered in Victoria. This factor is in turn impacted on by other variables including staff's dissatisfaction with teamwork (+0.05) and the complexity they experience in managing their own work (-0.10). These variables indicate that staff who are not happy with their work teams and perceive that they have little control over their work believe care (and specifically lower priority care) is missed more frequently.

High priority missed care is also impacted upon by an additional five variables: staffs' ability to self-manage their work tasks (-0.11), use of rounding practices (+0.09), satisfaction levels with their current position (+0.05), the nurse' gender (-0.06) and lastly, where their original qualifications were obtained (-0.05). Jointly these outcomes indicated that missed higher priority care is exacerbated by the effects of male staff, who are overseas qualified, believe they have little control over their work and are not satisfied with their current job.

Factors influencing day shift missed care scores

With reference to Figure 3.33, it can be seen that six variables have a direct influence on the total missed care scores for day shifts. Before exploring these in detail it is worth noting that day shift missed care scores are not influenced at all by the following variables; the nature of the employer (location and funding type), staff hours worked, their level of qualification, years of clinical experience, gender and current health status. Six factors have been shown to directly impact on day shift total missed care estimates. Treatment related missed care (+0.62) comprises the bulk of all missed care followed by higher priority care and of almost equal significance lower priority care (+0.242 and +0.24) respectively. These factors are in turn influenced by the effects of three other variables namely staffs' ability to manage their work day (+0.004) the units' use of rounding (-0.03) and staffs' satisfaction with their professional roles (+0.02).

Figure 3.33: Factors impacting on the type and frequency of missed care (day shifts)



As treatment_related missed care is the primary source of day shift missed care, it is worthwhile exploring what factors influence it in turn as a way of understanding care omissions more fully. The ability of staff to manage their own work is seen as a major predictor of treatment related day shift missed care (-0.33), followed by the younger age of staff (-0.15) and the wards' use of rounding is (-0.14). Other factors of almost equivalent variance in day shift treatment related missed care are the influence of overseas qualifications (-0.10), staffs' dissatisfaction levels with their current job (+0.09) and wish to change their current rosters (+0.07).

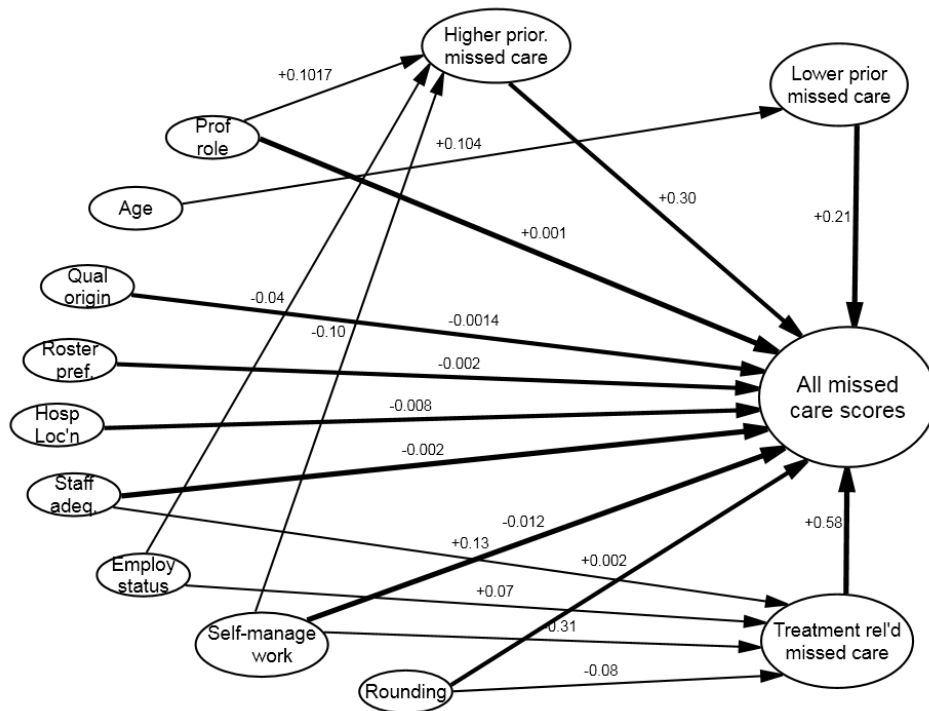
Day shift higher priority missed care is impacted by three variables: namely staffs' ability to manage their daily work events (-0.09), the use of rounding in the clinical area (+0.60) and from the older aged groups of staff (+0.05). Lower priority missed day care has already been seen to account for as much variation of this aspects of missed care as the higher priority care however, lower priority care scores are influenced by the effects of staffs' ability to manage their own work (-0.18), rounding practices (+0.90) and their dissatisfaction levels with their current position (+0.07).

Accounting for variance in afternoon shift missed care scores

There are four variables that have no effect on either the frequency or type of missed care on an afternoon shift. These factors include the nurses' gender, their level of qualification and the number of hours they are employed. Additionally whether staff were employed at a publicly or privately owned facility has no effect on missed care outcomes. The final

estimates of missed afternoon care are influenced by the same factors that impact missed care on day and night shift however, there are a total of ten variables which predict missed care on the afternoon shift. This can be seen clearly on Figure 3.34.

Figure 3.34: Factors impacting on the type and frequency of missed care (afternoon shifts)



The largest determinant of variance in missed care scores are those aspects of treatment related missed care (+0.58), followed by higher priority missed care (+0.30) and then by lower priority care (+0.21). The location of the hospital (rural) directly influenced afternoon missed care estimates as did the unit's use of rounding (-0.008 and +0.002 respectively). Staff qualifications (those not arising from Australia) is associated with increased missed care on late shifts (-0.0014) as is staff's dissatisfaction with their professional role (-0.001), the frequency in which they believe their unit is adequately staffed (-0.002), the level of control they believe they have over their daily work (-0.012) and lastly their preference to change their current roster schedule (-0.002)

As afternoon shift treatment related care estimates are the highest of all the total missed care figures it should be noted that this variable is in turn influenced by the effects of an additionally eight variables and includes the units' use of rounding (-0.08), staff's ability to manage their daily work (-0.31), full-time employment status (+0.07), staff age (0.-15), their country of origin of their qualification (-0.09), staffs' preferences to remain on their current roster (+0.07) and their perception of how often their unit is adequately staffed (+0.13).

Missed afternoon higher priority care is also influenced by an additional two factors and include staffs' capacity to manage their own daily work (-0.10) and their part-time employment status (-0.04). Missed afternoon lower priority care is in turn influenced by the two variables namely, older staff members (+0.104) and their degree of dissatisfaction with their professional roles (+0.10).

Why care is missed

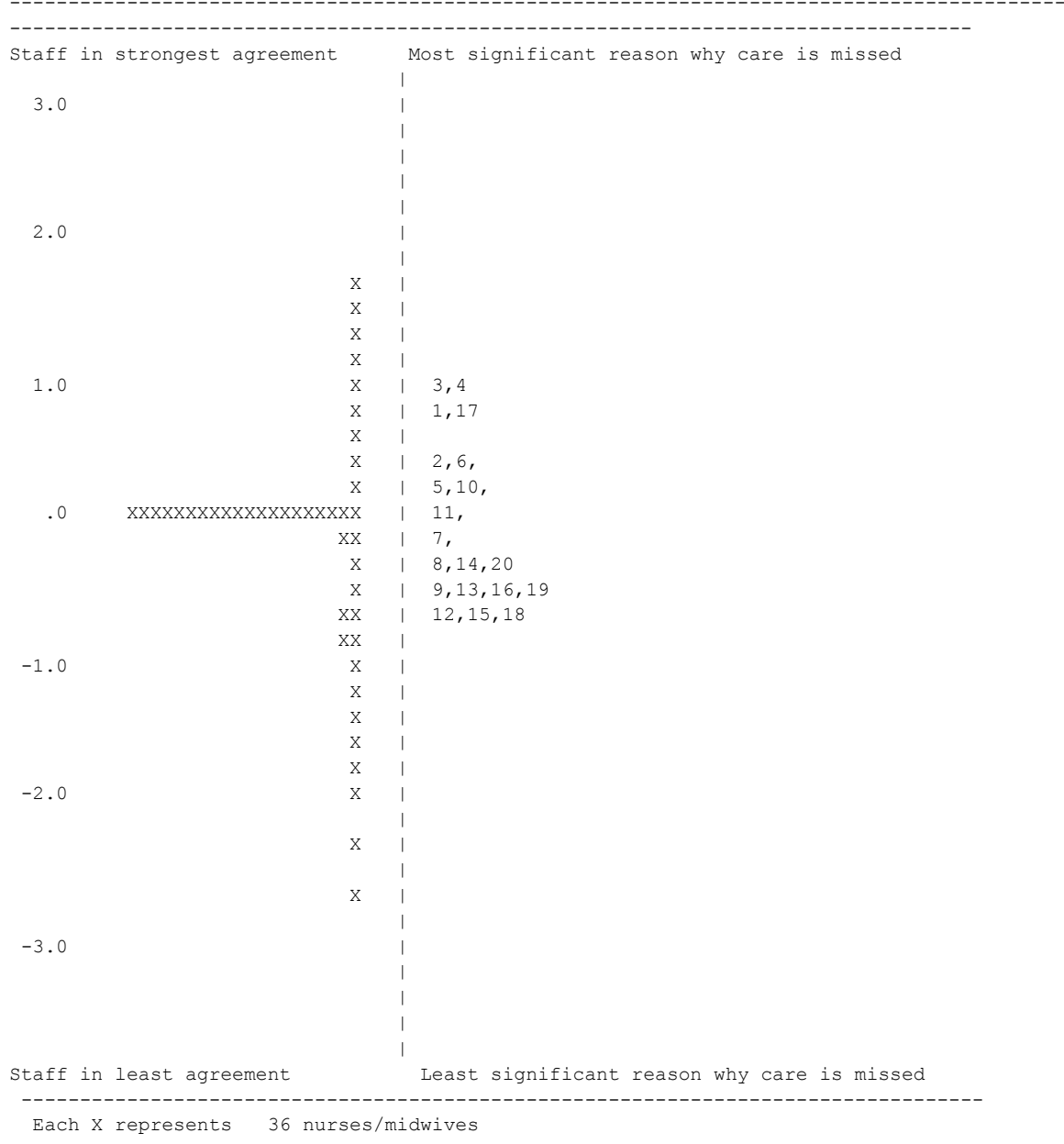
Table 3.2 itemises twenty different reasons as to why care might be missed in the clinical area and are extracted from the second part of the missed care survey.

Table 3.2: Descriptions of the types of reasons why reported nursing care was missed

Item no	Reason for reported missed nursing care	Item No	Reason for reported missed nursing Care
1	Inadequate number of staff	11	Lack of back up support from team members
2	Inadequate skill mix for your area	12	Tension or communication breakdowns with other ancillary/support departments
3	Urgent patient situations (e.g worsening patient condition)	13	Tension or communication breakdowns within the nursing/midwifery team
4	Unexpected rise in patient volume and/or acuity on the ward/Unit	14	Tension or communication breakdowns with the medical staff
5	Inadequate number of assistive and/or clerical personnel (e.g. care assistants, ward clerks, porters)	15	Nursing assistant/carer did not communicate that care was not provided
6	Unbalanced patient assignment	16	Nurse/carer assigned to patient off ward/Unit or unavailable
7	Medications not available when needed	17	Heavy admission and discharge activity
8	Inadequate handover from previous shift or patient transfers into ward/Unit	18	Registered Nurses and midwives/Midwives not available or not available in a timely manner
9	Other departments did not provide the care needed (e.g. physiotherapy did not ambulate)	19	Unable to access information technology (IT)
10	Supplies/equipment not available when needed	20	Wearing personal protective equipment (not able to access or use)

Figure 3.35 compares the relationships between the staffs' beliefs about why nursing care is missed based on their views of how important each of twenty factors/reasons were in contributing to missed care. In the figure to the right of the vertical line (called a logit scale line), are the item numbers that correspond with each of the twenty given reasons for missed nursing care addressed in the survey. Each item is located on the scale according to the significance of the reason for why care is missed.

Figure 3.35: Reasons why care is missed: Staff attribution scores



Item numbers occurring **near the top of the scale represent the most significant reasons** for why care is missed while item numbers located **toward the bottom of the scale as the least significant** for why care is missed. With reference to Figure 3.35, it can be seen that survey items 3 and 4, then items 1 and 17 are located at the highest point of the vertical scale. This indicates that these items, are identified to be the most significant reasons

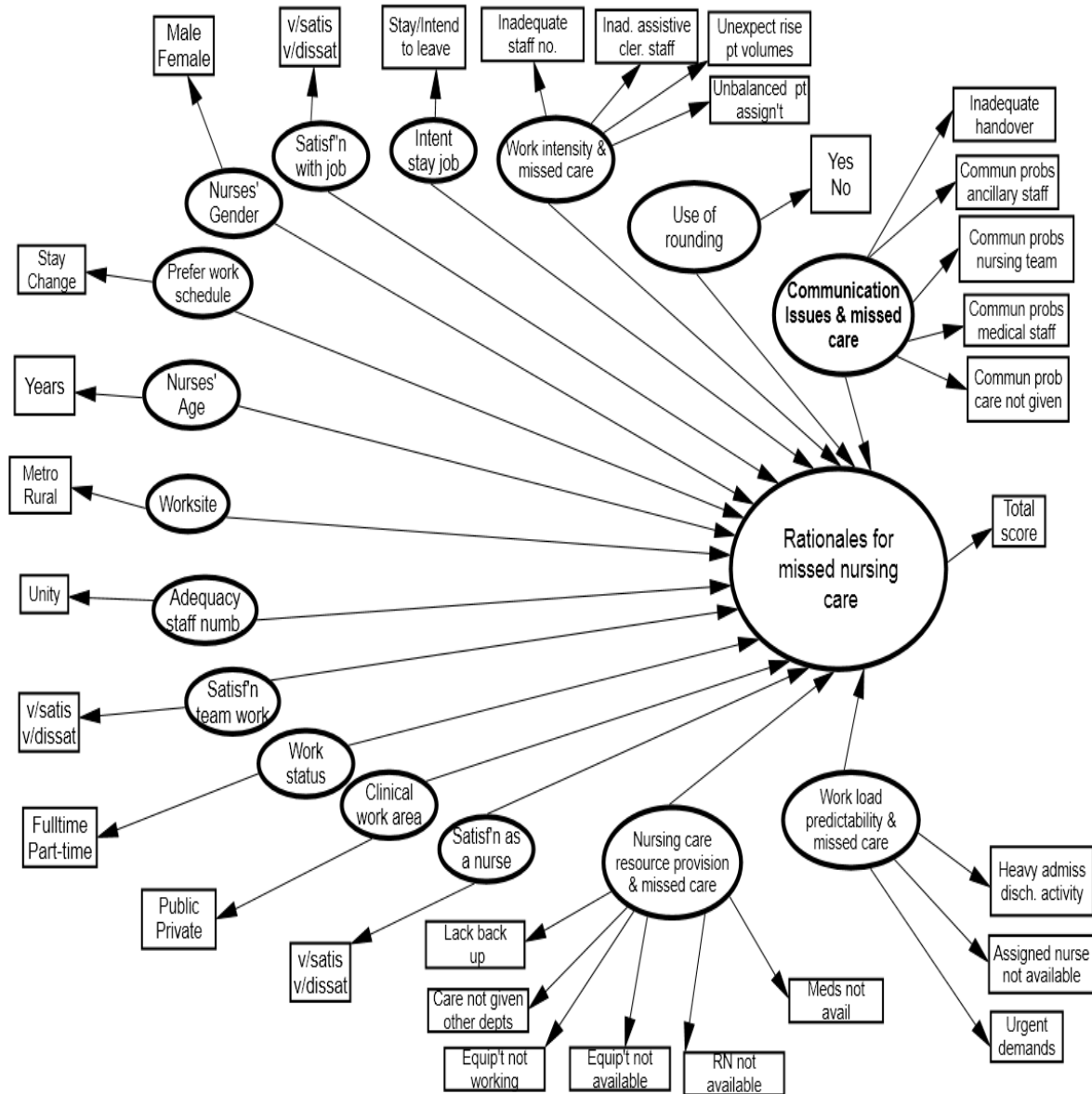
behind why care is missed. Item 3 (urgent patient situations) and item 4 (unexpected rise in patient volume) crystallise that it is workload unpredictability and work intensity that are the paramount reasons why care overall is missed. Inadequate number of staff (item 1) and heavy admission and discharge activity (item 17) again pinpoint that work predictability and intensity are the strongest contributing factors to missed care. Continuing down the scale in Figure 3.35, items 2, 6, 5 and 10 are then located. *Inadequate skill mix for your area, an unbalanced patient assignment together with an inadequate number of assistive and/or clerical personnel and supplies/equipment not available when needed* (Items 2,6,5 and 10 respectively) remain important reasons behind missed care and highlight the importance of an adequate supply of human and physical resources to avoid missed care. At the bottom of the logit scale three items 12, 15 & 18 (tension or communication breakdowns, staff not communicating that care was not provided and Registered Nurses/Midwives not being available or not available in a timely manner, respectively) are located. These reasons are the least important of all the other twenty given reasons behind missed care.

To the left of the vertical line are a series of X's, (each representing 36 nurses and midwives) located up and down the logit scale. Those nurses and midwives, who most strongly believed that the reasons given in the survey were largely responsible for missed care, are located in the upper range of the logit scale (adjacent to logit +1.0 to +2.0). From Figure 3.35, this would account for approximately 180 of the surveyed staff holding the strongest consensus for why care is missed. The majority of staff (about 600 nurses/midwives co-located at the zero logit on the logit scale) have moderate agreement with the reasons given behind missed care. The remaining nurses located on the descending or lowest aspect of the logit scale believe that the reasons given in the survey have minor or are of least importance in creating missed care.

Predicting why care is missed

Figure 3.36 identifies those factors that have been proven to influence why nursing care is missed from previous studies (Blackman et al 2015a). It is assumed that such factors will impact also on why Victorian nurses/midwives perceive care as missed. In this context the figure is seen as a hypothetical model requiring confirmation from the data supplied by the Victorian nursing/midwifery participants. Of particular note in the figure are the demographic variables, work intensity factors, resource allocation variables, factors depicting communication between staff and work predictability variables. All these variables are derived from the survey (Refer to questions 1 to 33 and question 52 in appendix A), and are demonstrated as the small rectangles in Figure 3.36. These factors (termed manifest variables) in turn reflect latent variables (developed in the diagram as ellipses) which will, it is hypothesised, influence the magnitude behind the reasons why nursing care is missed.

Figure 3.36: Variables or factors that are thought to predict why nursing care is missed as predicted by the Victorian nurses/midwives.



The following variables were found **not** to have a statistically significant influence of why nursing care was missed in the clinical environments studied in this project -participant nurse *gender*, the nature of the worksite either being *private* or *public*, *their preference for changing their current roster*, and *the number of hours worked*. None of these factors were a significant influence on the magnitude of why nursing care was missed.

In Figure 3.37 the variables that have a statistically significant direct influence on the nurses and midwives' beliefs as to why nursing care is missed are demonstrated. The scope of that influence is expressed as a value (a co-efficient), together with a listing of additional variables or factors that additionally influence why care is missed, but do so in an indirect way.

Another direct and significant predictor for why care is missed is communication issues within teams be it in the form of face to face communication or when using information technology. This factor is in turn influenced by an additional five other variables. These include dissatisfaction with team members (+0.21), staff dissatisfaction with their current workplace role (+0.12), when rounding practices are used (-0.09), the years of workplace experience (-0.12) and lastly age of the staff member (-0.10). With the effects of these additional factors, communication tensions are rated as highly significant for missed care particular for those staff who are both dissatisfied as a team member in their current role and in the presence of rounding practices. It should be noted that it is the younger staff and those with comparatively less clinical experience that identify communication tensions as a source of missed care, compared to older and more experienced staff.

Predictability of work was seen to be a direct and significant factor influencing why care is missed. Its impact is exacerbated by the additional factors impinging on it by six indirect variables. Increasing intensity of the workload (+0.17) further increase pressure of the (un)predictability of work, communication tensions (-0.09) and the location of the workplace (suggesting rural based workplaces, in particular) further influence workload predictability (-0.06). There are two other variables that have an impact on workload predictability as a reason for missed care. These are length of the nurses'/midwives clinical experience (-0.42) and the hours worked by staff (-0.41). The negative co-efficients representing these influences indicate that it is the staff with the least amount of clinical experience who work on a part-time basis who believe work predictability is a significant reason for missed care. Age, particularly for the younger nurse/midwife cohort also indicates statistical significance (-0.44) in identifying work load predictability as a factor behind missed care.

Team member dissatisfaction has a direct negative impact on the variable estimating why care is missed. With a co-efficient of -0.15, it is the fourth most significant influence on why care is missed and indicates that those staff who are not satisfied with the level of teamwork that exists in their workplace, see this as a reason behind missed care. There are no other factors impacting on staff's perception of the levels of workplace team work. A similar pattern exists for the final factor that significantly and directly influences why care is missed. The degree of work intensity as a mechanism behind why care is missed is estimated with a co-efficient of +0.14. This indicates that staff who believe their workplace experience increased work intensity, reciprocally believe that it increases the intensity for missed care. There are no other factors that impact on the perceived levels of workplace intensity identified by the respondent nurses/midwives.

Complexity of managing own work

The participants were also asked about the complexity of completing aspects of their work using a four point Likert scale. The scale ranged from being an extremely difficult task, to

simple tasks along a five point scale. These self- efficacy estimates were then used to determine how difficult staff saw these different aspects of managing their workload in the context of missed care. Table 3.3 displays each of the self-efficacy items used in the survey

Table 3.3: Survey items used to estimate staff self-efficacy

1	Work within own scope of practice	6	Delegate work to other staff where appropriate
2	Deliver care that is consistent with your own expectations	7	Provide interrupted nursing care
3	Deliver care that is consistent with your organisations' expectations	8	To be autonomous in how I deliver care
4	Collaborate with other disciplines when planning patient care	9	Implement nursing care in absence of policy or guidelines
5	Attending multi-disciplinary conferences		

Figure 3.38 indicates the majority of nurses (93 percent) found it easy or very easy to work within their scope of practice. The supporting qualitative data indicated that a small number of nurses and midwives made comment on this question highlighting some of the factors that might impact on their ability to work within their scope of practice. These nurses mentioned the constant interruptions to their work, the irritation of having to wait for doctors to sign off on particular care, when the nurse knew what was required, but was not accredited to perform the task. Both midwives and nurses who trained in other countries noted with frustration the fact that they were required to wait upon medical orders that they thought were within their scope of practice. Enrolled nurses also talked about the ambiguity of their role; where scope of practice was both limited and abused.

Another question related to autonomy and scope of practice asked nurses and midwives if their care met their own standards. This question was asked as it is at this point that nurses' own emotional response to work intensification is evident. Nurses may or may not work within their scope of practice, but if they are not working according to their own standards of care they are likely to experience burn out and emotional dissonance. As Figure 3.39 indicates approximately 70 percent of nurses who responded to this question (n=984) indicated they were able to deliver care according to their own standards. The majority of qualitative responses to this question came from nurses who were not satisfied with the quality of care they provided. They noted that they needed to prioritise care, rather than provide all that they thought should be offered; there were limitations on their scope of practice; lack of time to do all the care tasks they would like to perform for patients, or that they compromise care to fit the resources provided by the organisation.

Nurses were asked if their care was consistent with the organisation's standards (see Figure 3.40). Seventy-six percent of respondents indicated that they achieved this with ease or it

was very easy to do so. Once again qualitative comments tended to be provided by those nurses and midwives who found it difficult to meet the employing organisation’s standards for care. Given, *lack of resources* was one of the areas identified as causing missed care (See Figure 3.35, item 10), we expected more nurses to respond negatively to this question. Participants did note the organisation they worked for had high expectations, but did not provide the resources as the following quote demonstrates; “again a policy for skin tears as example but the dressing not available for staff to access”. The major issue for nurses was lack of time to meet the agencies care standards given the staffing levels. This is consistent with Figure 3.36 which indicates that unpredictable work results in increased intensity and in turn lack of time to complete all tasks.

Figure 3.38: Work within your scope of practice

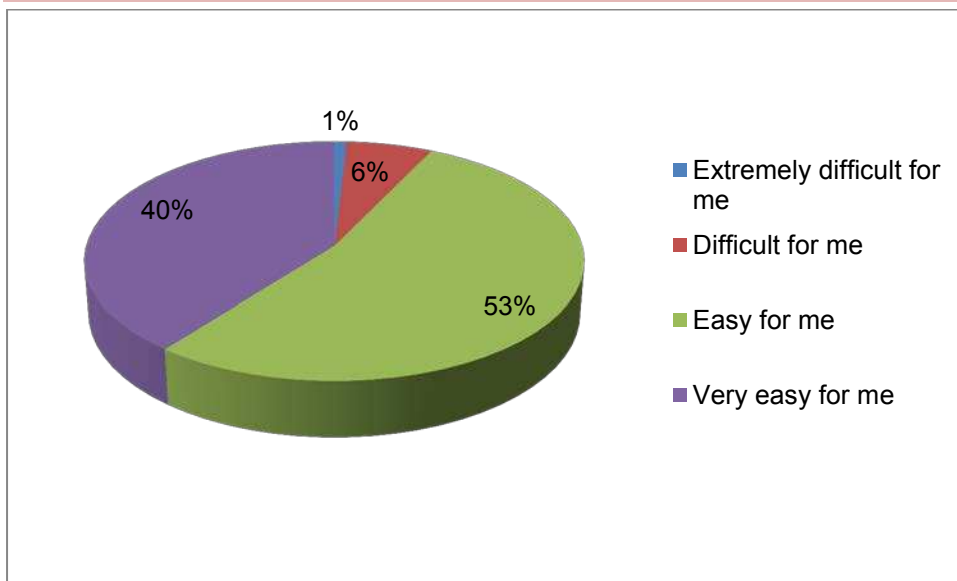


Figure 3.39: Deliver care that is consistent with your own expectations of practice standards

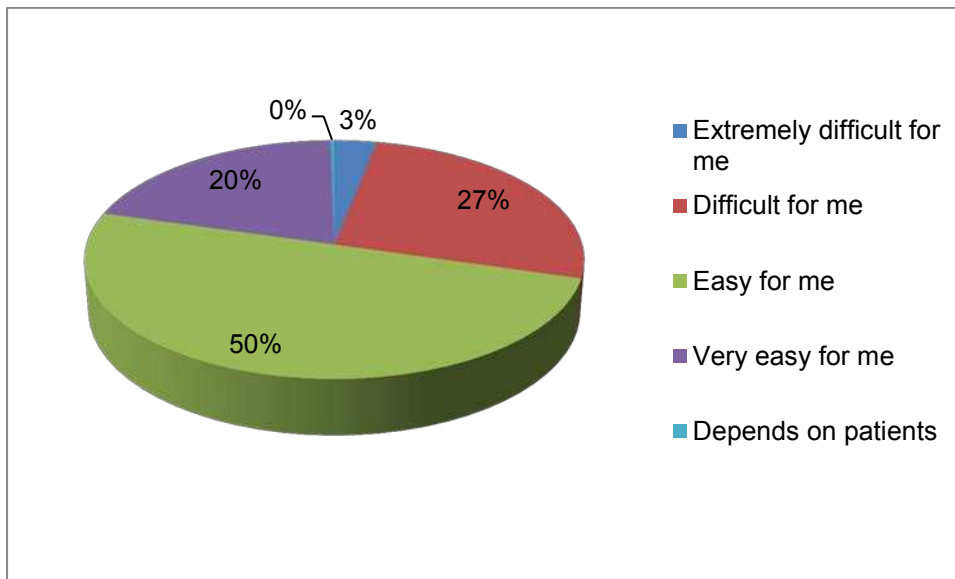
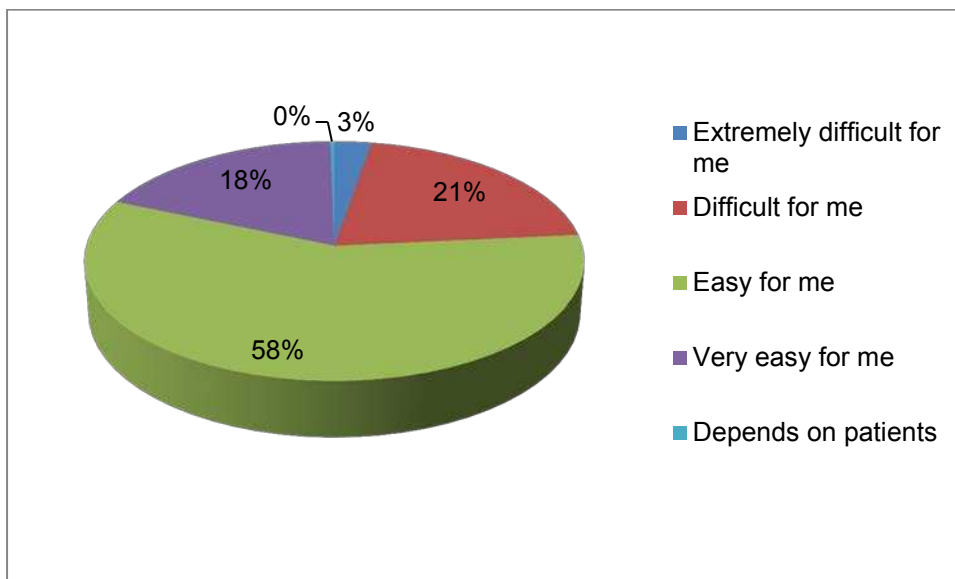


Figure 3.40: Deliver care that is consistent with your organisations practice standards



Team work

One of the keys to meeting the expectations of the organisation is the overall level of team work. The survey asked nurses and midwives to comment on collaboration with other health professionals such as doctors and allied health professionals. Eighty-five percent of respondents said that team work was easy to very easy to achieve. This is presented in Figure 3.41 below. In the qualitative responses (44) nurses noted that both doctors and allied health professionals were not always available, and that communication was often via

email or the patient notes. There were the usual comments about doctors not always communicating changes in orders but overall the response to this question suggests team work is not perceived to be a major issue in missed care. This is an unusual response to the question, given Figure 3.37 above where the path analysis shows that tensions between the care providers (+ 0.34, and satisfaction levels with members of the team (-0.15) rated 2nd and 4th in the four major reasons for missed care. It is possible that nurses regarded the team differently for each question; in the first question they understood team members to refer to other nurses, while in question 68 it clearly extended to multidisciplinary colleagues. In question 69 nurses were asked how easy it was to attend multi or interdisciplinary case conferences. Here the results switch and nurses report that this is very difficult to achieve. Fifty-one percent indicated it was difficult or very difficult, while 31 percent indicated it was easy or very easy. In the qualitative comments it was clear that of the 88 nurses who responded many misunderstood the question, or were on permanent night duty. Some nurses thought the question referred to conference attendance as part of continuing education, some reported that the nurse unit manager attended, but overall the responses suggest that nurses are not aware of case conferencing as part of patient care, or state the obvious; nurses cannot leave their patients to attend interdisciplinary meetings (See Figure 3.42).

Figure 3.41: Collaborate with other disciplines when planning and providing patient care.

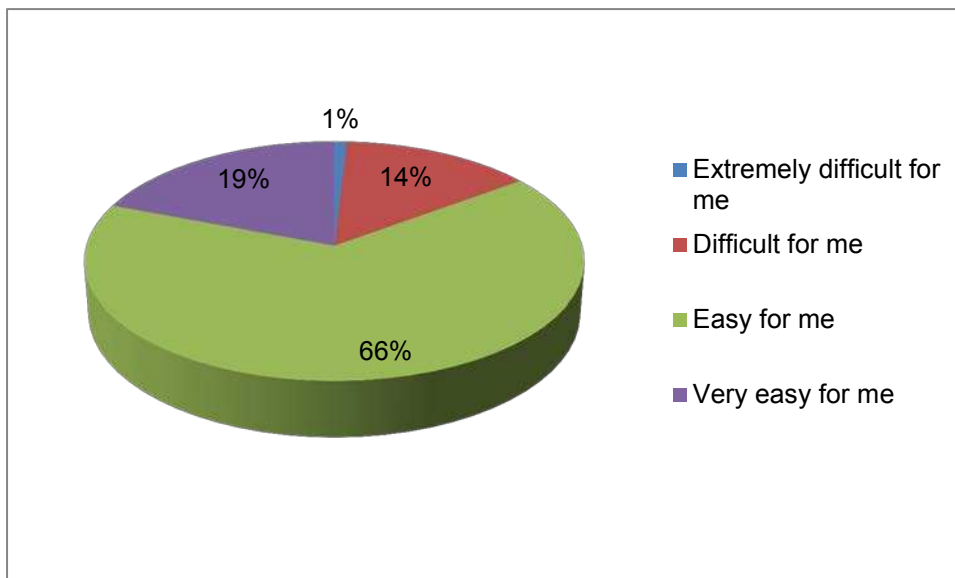
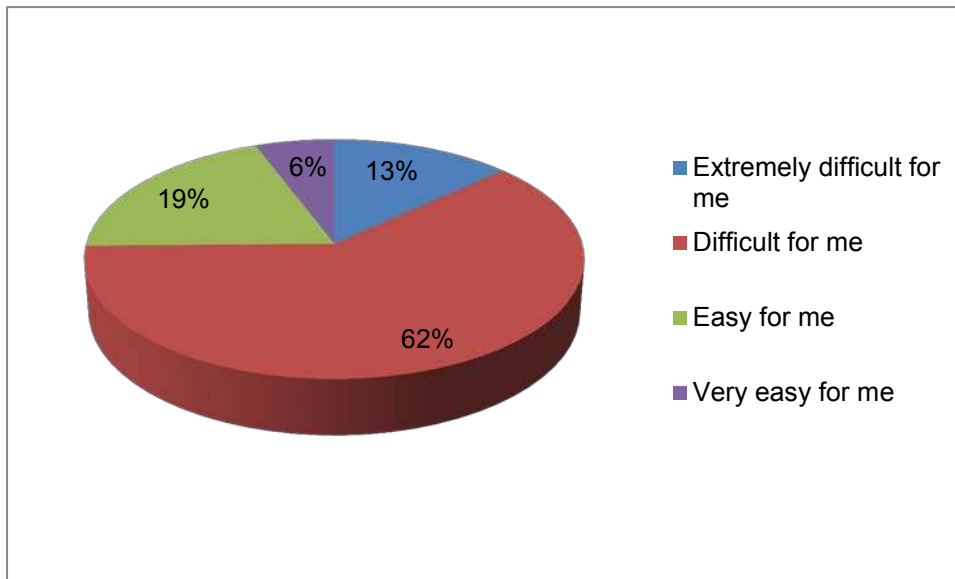


Figure 3.42: Attend interdisciplinary care conferences whenever held



As noted in Figure 3.43 around 69 percent of nurses and midwives found it easy to very easy to delegate work to other staff when required. Just over one half, 51 percent found it difficult to deliver care free of interruptions (Figure 3.44), with over 80 percent claiming to work autonomously (Figure 3.45). Figure 3.46 illustrates that around 70 percent of nurses and midwives felt they were able to deliver the appropriate care independently of specific hospital or organisational policies.

Figure 3.43: Delegate work to other staff where appropriate

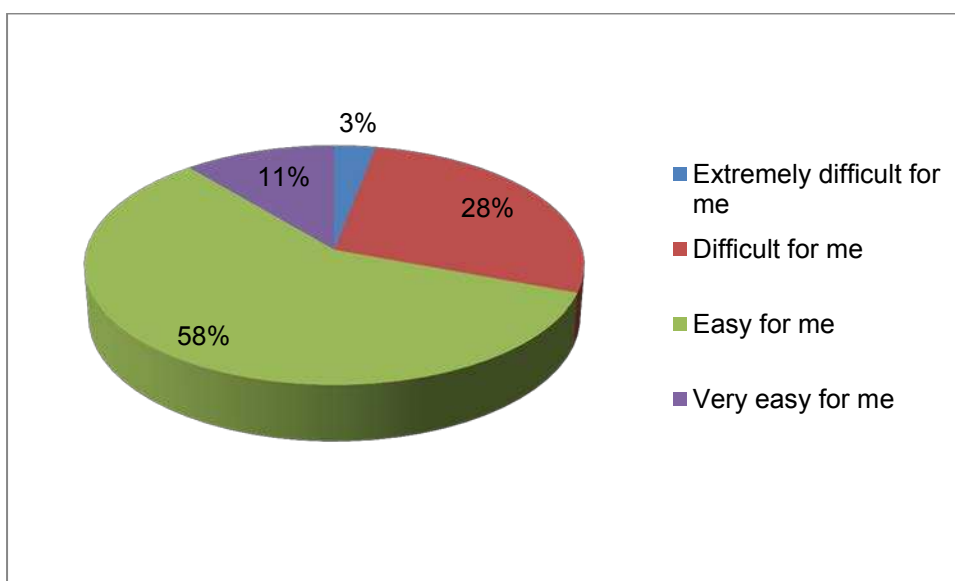


Figure 3.44: To deliver uninterrupted nursing care

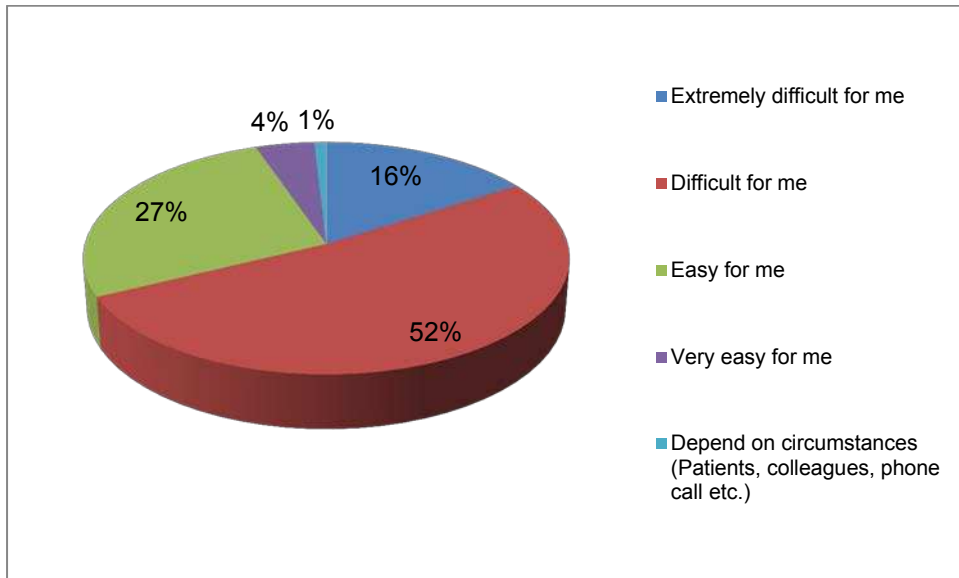


Figure 3.45: To be autonomous in how I deliver nursing care

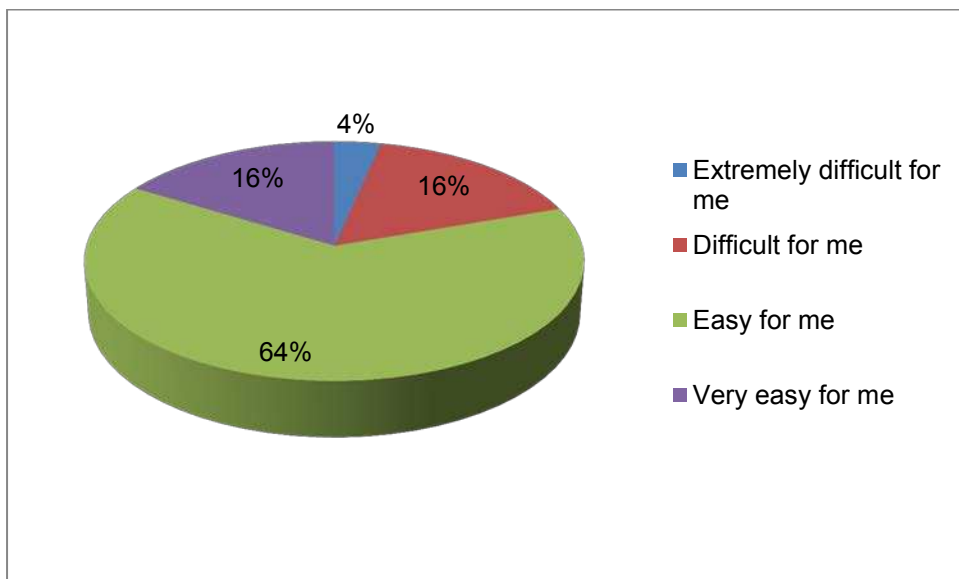


Figure 3.44: Implement nursing care in the absence of policies/procedure guidelines

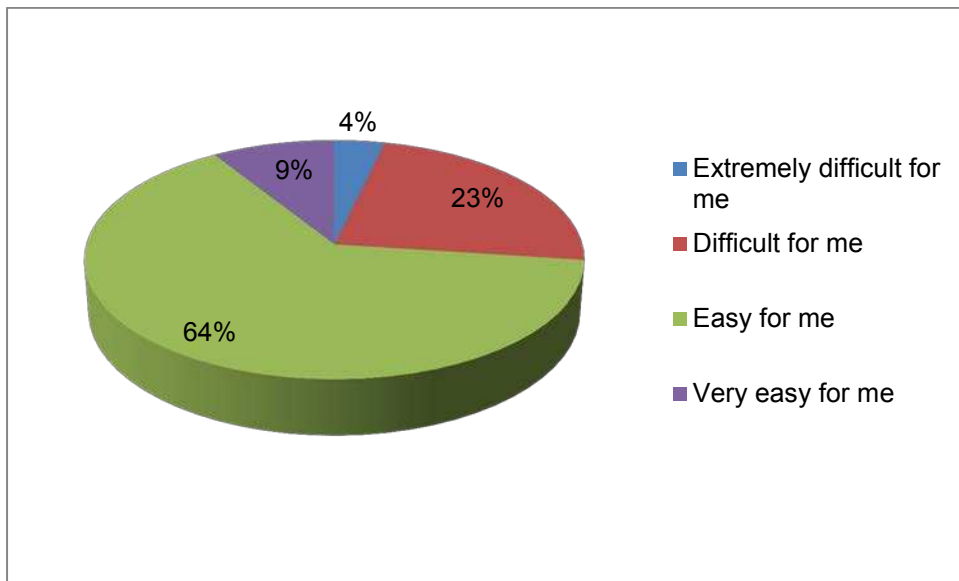
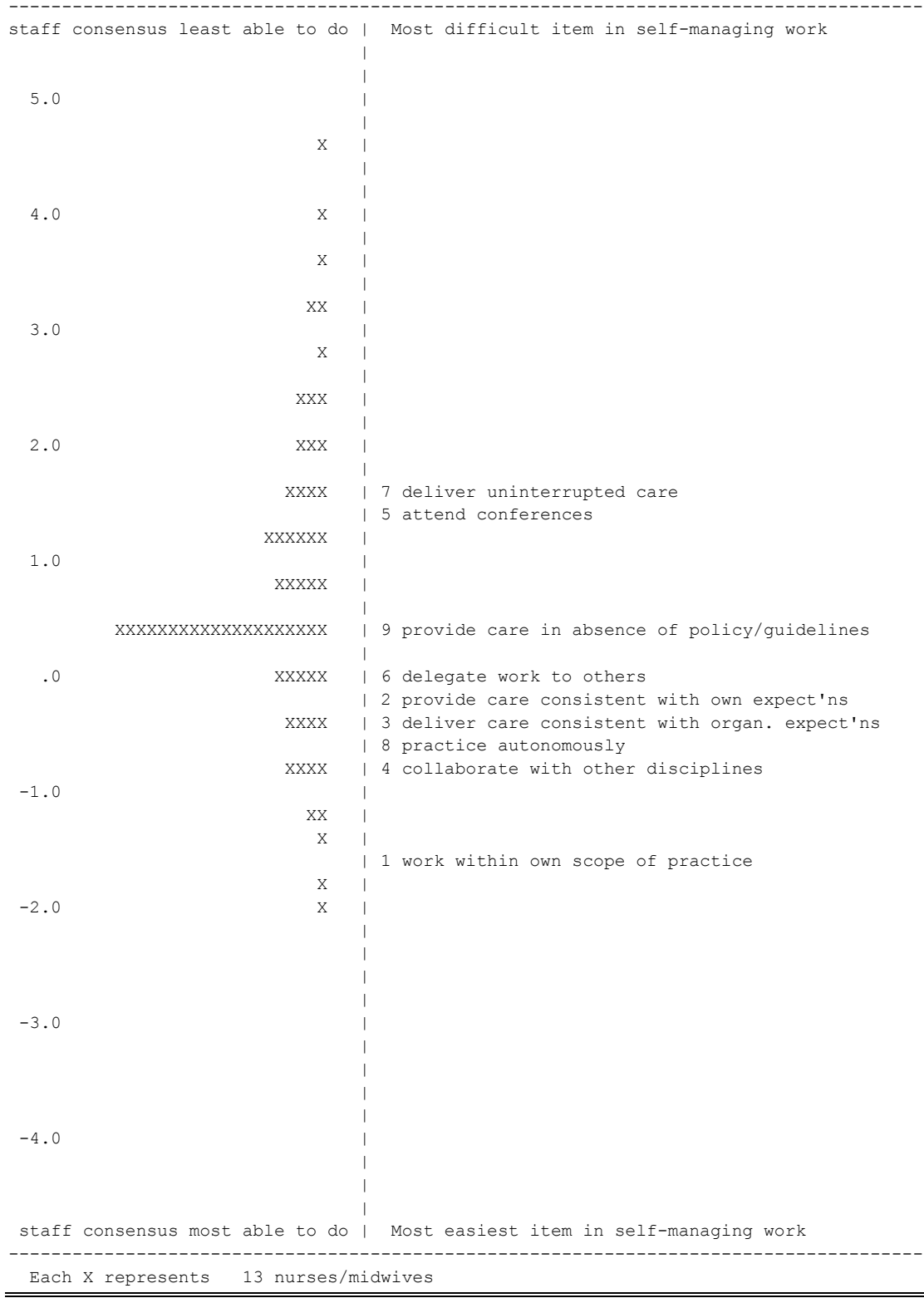


Figure 3.47 co-locates the abilities of the staff to manage their work, based upon how easy or difficult the nine items used to measure that attribute, were to do . On the right hand side of the vertical line, items 7 and 5 are the most difficult aspects of work staff find to manage on a daily basis. Indeed, this report has already demonstrated that self-managing work was seen to have a direct impact on the frequency and type of missed care. The next most difficult aspect of managing care is doing this in the absence of guidelines or policy (item 9). It is at this point and descending down the scale in Figure 3.47, that staff report the self-management of work becomes progressively easier for them, including work delegation, meeting own and employer expectations and standards and being able to practice autonomously and collaborate with other staff. Working within scope was viewed by staff to be the least complex of the self-efficacy tasks.

Figure 3.47: Self efficacy estimates of managing work based on staffs' self-rated abilities



Chapter Four: Qualitative Findings

Additional information was collected from open-ended questions that asked respondents to comment further on missed care in their work area. The following data was collated from responses to a question asking participants to comment on “Is there anything else you would like to tell us about missed care?” This question was completed by 284 participants. Answers to this question addressed both understandings of and reasons for missed care.

Understanding Missed Care

When asked about missed care, respondents to this survey cited discrepancies between management expectations and capacity to deliver care. One nurse said “[t]he organisations talk about patient centered care and while I think the policies are reflecting that aim in reality it is very difficult if not impossible to meet the needs of patients.”(30). Another nurse identified difficulties in meeting quality standards. This nurse stated that:

...quality and quantity is a continuous jigsaw to keep balanced safely. Outcomes and expectations override physical capabilities of great nursing care these days. Patients and scenarios are multi complex and challenging to balance. The tasks and standards outweigh the capabilities one can achieve with [the] numbers of staff and time frames (21).

As a consequence, nurses describe prioritising or delaying nursing care. Schubert et al. (2008) argue that nurses respond to increased work demands and insufficient resources through prioritising and rationing the care they provide. For Papastavrou et al. (2014) rationing is associated with priority setting with nurses deciding which care to give to optimise patient outcomes. This approach was evident in this study. A third nurse stated that:

All staff must prioritise their workload and unfortunately as this will not impact the patients’ life immediately, it is often missed as the work now is so complex and urgent. Hospitals are now run as a business and as long as beds are filled, nursing staff are expected to provide optimum care in an unrealistic environment (58).

The nursing care that is most frequently identified as being missed is basic nursing care and patient education. In acute care, basic nursing care is missed. A nurse stated that: “[a]t times the life-saving care must be delivered at the expense of other care” while another stated that “[a]lthough it seems minor, often mouth care, perineal care, positioning, [and] completing the fluid balance gets missed mostly by junior staff.” (197). Midwives identified insufficient time to undertake patient education. A midwife argued that:

In midwifery the hardest thing to achieve is quality education. The women and their families are in and out too quick to achieve quality education over a range of topics. For example, if we could spend more time with individuals wishing to breastfeed then there would be higher rates of babies continuing to breastfeed once discharged home and beyond leading to healthier children and adults (222).

Often unfinished care is passed onto the next shift, adding to workload on that shift. A nurse in reflecting on this said:

Time constraints lead to rarely being able to conduct all tasks in every shift. Nurses need to handover tasks to the next shift which they feel terrible about as they know that the next shift will also have time pressures. The nature of ever changing conditions and the need to explain all nursing care to patients, [lead] to many nurses feeling exhausted at the end of their shift. They also feel unsatisfied if they do not manage all the tasks even when they know that it was too much work to be done within the shift (12).

Another nurse reflected upon the delaying of tasks from the late shift to night duty when less staff are available.

...it is very difficult to "catch up" if the shift prior has missed nursing care - as there needs to be extra work done and meds retimed etc.... if the continence round is not done or the 1800 meds not given to 1900 when the afternoon shift goes home and the 2 night shift staff need to catch up with the care!! It is not ideal but is a fact of life so 2 people are trying to do the work of the 4 or 5 on afternoons (86).

Reasons for missed care

Respondents to this question identify many reasons as to why care may be missed. Among these are: cost containment, time constraints, staffing issues, patient acuity, juggling competing demands, access to resources and issues relating to communication and teamwork.

Cost containment

Cost containment and development of a business ethos was identified by many nurses as contributing to missed care. An experienced nurse in reflecting upon this said that:

Nursing has changed a lot in the 24 years since [I] first started. We now may be seen as a profession but the focus is on money and the business, not on patient care. We seek patient satisfaction but have lost the art of "caring" to paperwork (10).

Respondents to this survey associated cost containment with employment of midwives to work over multiple wards (61); admission of patients to days surgery beds which are not counted in the hospital census (69); poorer patient outcomes (103); and unpaid overtime (169).

Time constraints

Nurses identified insufficient time to complete all nursing care, leading to missed meal breaks and unpaid overtime to complete care. A nurse commented that "[i]f I had more time I wouldn't miss as much nursing care" (200) while another notes that "as well as missed nursing care there is a trend for missed nursing breaks also" (236). Missed nursing

care is also associated with the regulation of time. A renal nurse commented upon the impact of the establishment of a set appointment time of 15 minutes upon missed care:

In our dialysis unit there is pressure to meet 15 minute patient appointment times so that 3 shifts - morning, afternoon and late evening can be on time. There is little time to check a patients' file and requested pathology requests can be missed and therefore postponed till next treatment (53).

Staffing issues

Lack of staff was commonly identified as contributing to missed care by Victorian nurses. In contrast, to survey results from nurses in New South Wales and South Australia staffing methodologies were not widely critiqued (Verrall et al. 2014; Blackman et al. 2015a). The method for staffing public sector hospitals in Victoria is ratio staffing. Critique of staffing ratios in these hospitals is largely limited to after-hours shifts eg: night duty and weekends. A nurse working on night duty identified:

As per night shift ratios 3:32, some tasks we are expected to complete during the night seem to be more clerical based and can keep a nurse from the bed side. Some wards expect handwritten nursing notes on every patient, even if all care was delivered as per NCP and no exceptions to be recorded. Folders are re-organised, prepared for the following day. Paperwork for early transfers, early breakfasts, 8 am. medications and OBS [observations] are performed by nightstaff. If a patient needs assistance with breakfast, that leads to a ratio of 2:32. I find the practice of administering DDs at 6 am unsafe as it takes two staff, you wake the patients which results into patients needing toileting etc. so the ratio at that point is 1:32! Seldom is that round uninterrupted and the fact that one is tired (9 hours since starting the shift) may lead to mistakes (166).

Nurses in other setting such as aged care, rural hospitals and private hospitals are more critical of staffing methodologies. A respondent from aged care said that "staff ratios & untrained staff hinder care to residents" (194) while another called for fixed "staff ratios in aged care" (213). A nurse from a rural hospital argued that "nurse patient ratios in ALL hospitals should be the same" (216) a sentiment echoed by a nurse in a private hospital who stated:

Private hospitals must comply with 1:4 ratios. Why does a patient in a private hospital get a reduced standard of care? The ratios are there for staff and patient safety, yet this is only important in a public hospital? (247).

A second staffing issue related to access to other staff notably ancillary and medical staff. A number of respondents identify issues arising from lack of orderlies and PSAs. A nurse stated:

At my current organisation, there are no orderlies so you have to take samples to path[ology] or any other general need that orderlies do you have to do, therefore

away from nursing duties. We are still supposed to strip rooms after a patient has left. This should be part of the PSA duties (19).

In other settings there is evidence of cost savings made through loss of ancillary staff. Another nurse stated that “[d]ue to cuts to ward clerks and receptionist hours, nursing staff are expected to pick up the work of clerical staff. Is it any wonder that patients miss out on some care”(204). Lack of ancillary staff is particularly problematic after-hours. Another nurse identified time spent compensating for lack of staff.

The hospital I work in, like many others, I'm sure, do not provide adequate services outside business hours (allied health, radiology, pharmacy etc), meaning nurses often have to fill the gaps, for example sitting in radiology with patients because there is no nursing staff. This leaves the remaining patients in my care without their primary nurse, sometimes up to 45 minutes. Or running to other departments to track down medications (52).

Respondents also identified issues arising from lack of access to medical staff. Nurses identified time spent in chasing medical staff. “Missed nursing care [occurs] because the nurse has to chase Doctors to remind them to chart medication or ask for PRN (especially difficult overnight on wards when doctors are rarely available)”(209). Lack of access to medical staff after-hours was also associated with difficulty in getting orders changed.

A final staffing issue was skillmix. While frequently identified as an issue there was little discussion of what aspect of skillmix contributed to missed care. Victoria employs Health Assistants/Personal Care Assistant (PCAs) to deliver some care. Some respondents viewed this as leading to poorer care. A community nurse associated poorer patient outcomes with “patients [being] looked after by unskilled PCAs”(246). Conversely, others called for use of PCAs to perform basic nursing care. Another nurse stated that: “If there were PCA's to help the RN's to ease their workload, it would make it so much easier for RN's to focus on the acute needs” (197).

Patients' acuity

Another widely cited reason for missed care is patient acuity. There is a perception that patients acuity has increased. A nurse noted that “patients are becoming more complex with many co-morbidities and this contributes to the difficulty in providing care” (30). Unlike respondents from New South Wales who identified the ageing of the population as a key issue, Victorian nurses focused upon the workload associated with managing patients with behavioural issues associated with dementia and mental illness (Blackman et al. 2015). This was evident in both acute and aged care. An acute care nurse outlined the difficulties of managing patients with dementia in acute care setting. “[N]ursing homes contin[ue] to send to hospital patients that they cannot care for due to behaviours. It's not any easier in an acute hospital setting when you have to continue to leave an unstable patient to try and

keep your patient on the ward and safe”(68). Similar sentiments are expressed by nurses working in aged care. Another nurse said that “[w]orking in dementia care [is] difficult as [we] have 30 patient load with many of patients displaying aggressive behaviours, therefore makes nursing care to other patients difficult (70). Psychiatric patients were also identified as difficult to manage. Another nurse stated that: “Psychiatric patients [are] also difficult to care for in hospital system especially when aggressive or frequently trying to leave” (73). A final group of patient identified as increasing workload are obese patients. “We are getting many more obese patients, which may need 4 staff to attend to, which leaves the rest of the floor understaffed while the obese patient is being attended too” (252).

Competing demands

Competing demands also contribute to missed care. The most commonly identified task which created difficulties in completing nursing care was the volume of documentation to be completed in both acute and aged care. A nurse argues that:

One major factor that appears not to be taken into account is that to satisfy all the EVER increasing documentation requirements of the various disciplines that form patient care (of which nurses are the "hub") is that every new "it'll only take five minutes" task comes out of a shift that remains the same length. So patients are sicker/more complex and documentation more onerous but compulsory so sadly basic nursing care (ie: hygiene, feeding, listening, reassuring etc) gets missed (4).

Accreditation (19), rounding (16) and audits (143) all add to documentation in acute care settings with rounding in particular, associated with duplication of paperwork.

A second factor which contributed to missed care was unplanned or unexpected events. Patient deterioration (232); the need for nurses in rural hospitals to cover emergency services (25); falls (31) attendance at MET calls and other emergency events (37); and births for midwives (145) all take nurses away planned care. The following quote from a nurse working in emergency exemplified this:

Missed nursing care can be about not having the appropriate amount of staff for the volume of patients, it is about not having access to appropriate care (no ICU/CCU/ HDU/paediatrics/ orthopaedics/plastics/neuro etc), having to manage all deteriorating patients for the hospital in the emergency department as well as all the emergency patients, having to leave emergency patients to go to all MET calls, code blues and code greys using existing staff numbers (37).

A final issue which lead to demands that take nurses from patient care is the volume of admissions and discharges. Nurses identify pressure to discharge patients to allow new patients to be admitted:

I believe that due to the high flow and acuity of the patients, nursing staff often feel challenged to deliver a high standard of nursing care because of the ongoing pressures

from every other department to get patients out in order to get patients in!!! It has become like a production line (108).

New admissions add to workload. A nurse stated that “[s]hifts frequently commence with inadequate staff, and there is always more admissions”(267). . Admissions can also add to team workload. A nurse working in ICU identified difficulties in getting “help from the access nurse at times if there is very unstable patients in the unit or a large number of admissions or discharges”(142). Admissions and discharges are also associated with time consuming paperwork. A midwife stated that:

I was recently with my father when he was admitted for surgery and it took the nurse nearly 1.5 hrs to admit him, this took her away from other patients. I can take 1-2 hours to discharge a woman from a post-natal ward if the discharge paper work has not been started already, it can take longer if the women are complicated. Even though you are supposed to commence discharge on admission, this does not always happen (19).

Access to equipment and resources

Chasing missing equipment and resources also takes nurses from nursing care leading to missed care. This is particularly evident with medication. A nurse stated that “medications [are] not supplied by pharmacy, incorrect drug orders on medication charts.....care is not given in a timely fashion due to lack of resources and time (271). Lack of equipment is also cited. Another nurse associated missed care with a number of factors including “no supplies to complete the task, unavailable med[ications] overnight. [and] unavailable or broken equipment” (151).

Communication and teamwork

A final factor contributing to missed care are difficulties relating to communication breakdown and poor teamwork. Respondents identify communication difficulties arising from employment of staff for whom English is a second language. One nurse noted that it is “sometimes difficult to understand staff from foreign countries as to what care is needed”(14). Another nurse highlighted difficulties with comprehension and unwillingness to seek clarification:

Communication barriers play a large part in missed care as it has been noted in my workplace that some staff with ESL do not actually understand the directions given even when asked if they understand or know what is expected of them, they say that they do (34).

Other nurses identify poor communication by different care providers as leading to missed care (39). Another nurse stated that “Doctors don't always inform nurses of changes to medications or tests. Lack of communication contributes to missed patient care” (171). Poor teamwork and breakdown of communication within teams is also implicated in missed

care. A third nurse stated that “[i]ncreasingly also teamwork is becoming compromised simply because every nurse on the shift has an unreasonable workload most of the time, and therefore not placed to assist colleagues” (267).

Conclusion

Many of the qualitative responses offered by nurses reflect the quantitative responses. Nurses identify difficulties in completing tasks when work intensifies due to increases in patient acuity, admissions and discharges, and chasing missing equipment. They also identify volume of documentation as preventing the delivery of basic nursing care. The role of other staff is also highlighted. For some nurses cost containment has resulted in removal of support staff leaving nurses to perform more non-nursing tasks while for others, poor communication from and the need to chase medical staff contributes to missed care. Finally, nurses working in aged care; the private sector and in rural hospitals argue that current staff: patient ratios prevent the delivery of good care.

Chapter Five: Bringing it together

This chapter brings together the key findings from both data sets and teases out the factors which contribute to missed care. Where data is available, comparison is made with results from the survey conducted in South Australia, NSW and New Zealand. There are slight differences between the NZ survey and the SA, NSW and Victorian surveys in terms of phrasing of some questions, but the over-all congruence is evident. In the first section we briefly revise the items of missed care across the three shifts, and then compare these with SA, NSW and NZ studies (Henderson et al. 2013; Harvey et al. 2013; Blackman et al. 2015a). This section also reports on those demographic factors that make a difference given the high proportion of nurses and midwives working part time in Victoria in both the public and private sectors.

In the second section we examine the causes of missed care identified by nurses and midwives in Victoria. This includes some observations about stacking (Ebright 2010) and the impact of rounding on missed care. Both qualitative and quantitative data has been used to examine the issues.

What care is missed

Table 5.1 lists the five top care tasks most often missed across the three shifts. There is significant overlap in the order in which these tasks are reported as being missed across the shifts. All but monitoring fluid input and output can be categorised as intermediate or treatment related priority care using the Alfaro-Lefevre (2008) hierarchy of care. The first point to make is that four of the five tasks can be delegated to Assistants in Nursing/Health Assistants; these include feeding patients while the food is hot, ambulating, patient hygiene including mouth care, and toileting. In chapter 3 we noted that these omissions were reported by older staff members who qualified in countries other than Australia, were employed in the rural sector and where rounding practices are used. While nursing care associated with lower priority tasks such as discharge planning and patient education were reported as missed, they are less likely to be missed than the intermediate level tasks. The significant variables impacting on lower level tasks were staff who are not happy with their work teams and perceive that they have little control over their work. In the case of high priority missed care the individual nurse's capacity to self-manage their work tasks, satisfaction levels with their current position, gender and lastly, where their original qualifications were obtained were significant indicators of reported missed care. Jointly these outcomes indicate that missed higher priority care is most often reported by male staff, who are overseas qualified, believe they have little control over their work and are not satisfied with their current job.

Table: 5.1: Five most common missed care items

Morning	Afternoon	Night
Assist in ambulating three times a day or as ordered	Assist in ambulating three times a day or as ordered	Assist in ambulating three times a day or as ordered
Oral Hygiene	Oral Hygiene	Oral Hygiene
Assist with toileting needs within 5 minutes of request	Assist with toileting needs within 5 minutes of request	Feeding patients while food is still warm
Monitoring intake/output as ordered	Monitoring intake/output as ordered	Patient education about illness, tests and diagnostic studies
Feeding patients while food is still warm	Feeding patients while food is still warm	Assist with toileting needs within 5 minutes of request

When comparisons are made between states there are considerable differences, although not marked variations from the Kalisch et al. studies (2006; 2009). For example, in the South Australian study conducted in 2012/3 the top five missed care tasks were *interdisciplinary case conferences, ambulating patients, mouth care, responding to bells in a timely manner and turning patients every 2 hours* (Henderson et al. 2013). In the New Zealand study the five top items were *ambulating patients, patient rounds, mouth care, fluid monitoring and patient washes*. (Harvey et al. 2013). The missed care tasks are more evenly spread across the lower/intermediate/high priority categories. However it is difficult to know if this is significant in any way.

Differences in missed care between Victoria and NSW

Table 5.2 identifies differences in missed care across shifts in Victoria and NSW. What is of particular interest is the different patterns of missed care over shifts. There is rater variation across shifts in NSW. For example, nurses on NSW day shifts suggest that monitoring BSL is missed regularly, but this type of patient scrutiny is not lacking over the next shift of care. This missed care pattern is completely different for the Victorian cohort. Examining the day and afternoon shifts of Victorian missed care, the same elements of missed care pervade and extend throughout the three shifts. This pattern does suggest that the elements of Victorian care are not just missed by one shift of staff, but extend for much longer periods suggesting that some aspects of care are not given at all (eg: assists with ambulation, providing mouth care, assisting with toileting, monitoring fluids and output and ensuring patients have their meals soon after it has arrived for them. This pattern of missed care also suggests that staff may be making decisions as to what aspects of care can be rationalised in

a time stretched clinical environment focusing instead of delivering care that cannot be withheld.

Table 5.2: Five most common omitted tasks NSW and Victoria across all three shifts

NSW day shift	NSW late shift	NSW night shift	Victoria day shift	Victoria late shift	Victoria night shift
BSL monitoring	Feeding patient while food is warm	Monitoring input/output	Assist in ambulating	Assist in ambulating	Assist in ambulating
Patient education	Emotional support	Vital signs as ordered	Oral hygiene	Oral hygiene	Oral hygiene
Patient bathing and skin care	Patient discharge planning	Prn medications within 15 minutes	Assist with toileting	Assist with toileting	Feeding patients while food still warm
Hand washing	Setting up patients for meals	Setting up patients for meals	Monitoring intake/output	Monitoring in take/output	Patient education about illness
prn medication within 15 minutes	Medication administered within 30 mins of schedule	Patient bathing and skin care	Feeding patients while food still warm	Feeding patients while food still warm	Assist with toileting

Do mandated nurse-patient ratios explain the difference?

The relationship between the frequency and types of missed care and mandated staff-patient ratios has not been unequivocally proven to be a significant factor in reducing missed care in this study. Despite Victoria being one of only two jurisdictions world wide with mandated nurse-patient ratios all but 6 percent of participants cited staffing shortfalls as a problem at least some of the time. Six percent stated that they always had adequate staff, as against 8 percent in NSW. Forty-seven per cent stated that staffing levels were adequate 50 percent of the time. Fifteen percent saw staffing at adequate levels 25 percent of the time. Five percent of respondents thought that staffing levels were never adequate.

There are however, differences in the frequencies of missed care reported by staff in both states. Specifically, the averages for frequencies of total missed care scores is the same for both the morning and afternoon shifts for NSW staff. In other words, shift time during daylight hours in NSW, does not influence the overall (average) frequency of missed care. Victorian nursing and midwifery staff on the other hand, indicate that the average frequencies of total missed care is significantly less overall for afternoon and night shifts compared to NSW however, but is equivalent with the morning shifts. In other words, while missed care in Victoria is less during late shifts, the incidences of missed morning shifts of Victorian care is similar to that of NSW. To what extent this difference can be attributed to

mandated staff ratios is difficult to judge specifically, as there is little differences in missed care between the states during morning shifts, when peak activity occurs in the clinical area and when maximum staff coverage would be reasonably expected to be rostered on. Despite this, there is some evidence that inadequate staffing is less problematic in Victoria. Inadequate staffing is rated lower as a cause of missed care in Victoria. More studies and analysis is needed to pinpoint the effects of mandated staff-patient ratios on missed care frequencies.

Reasons for missed care: Uncertainty, unpredictable and disorganisation

Table 5.3: Five top reasons for missed care in NSW, SA, New Zealand and Victoria

NSW	SA	New Zealand	Victoria
Provision of resources for nursing care	Unexpected rise in patient volume and/or acuity on the ward/unit	Increased acuity of patient workload	Urgent patient situations (e.g. worsening condition of patient)
Urgent patient situations (e.g. worsening condition of patient)	Inadequate number of staff	Urgent clinical situations	Unexpected rise in patient volume and/or acuity on the ward/unit
Unexpected rise in patient volume and/or acuity on the ward/unit	Urgent patient situations (e.g. worsening patient condition)	Inadequate number of staff	Heavy admission and discharge activity
Inadequate number of assistive and/or clerical personnel (e.g. care assistants, ward clerks)	Heavy admission and discharge activity	Unexpected rise in patient volume (and/or acuity of the ward)	Inadequate skill mix for your area
Heavy admission and discharge activity	Inadequate number of assistive and/or clerical personnel (e.g. care assistants, ward clerks)	Heavy admission, discharge and transfer activity	Unbalanced patient assignment

When nurses and midwives were asked what were the underlying causes of missed care these could be categorised under two major heading; issues of uncertainty and unpredictability, and issues of systemic disorganisation (see Table 5.3). Unpredictable and uncertain causes of missed care were *urgent patient situations, unexpected rise in patient volumes, inadequate numbers of staff, and heavy admissions and discharge activity*. These activities are part of the uncertain and unpredictable nature of hospital life and nursing

work that are difficult to plan and roster staff to accommodate. Dealing with these unpredicted events requires nurses and midwives to re-prioritise their care and to make decisions about what can be omitted and what cannot. It is not surprising that patient education and discharge planning is stacked behind the intermediate nursing tasks, given nurses know the patient may well be on their own, once discharged. Nurses and midwives also noted that *Inadequate skill mix for your area, an unbalanced patient assignment together with an inadequate number of assistive and/or clerical personnel and supplies/equipment not available when needed* were also contributing factors. These items can be predicted. They point to what Elridge (2010) defines as system based issues, outside the control of the individual nurse. The solution lies in care re-design at an organisational level and can be categorised as issues of system disorganisation.

What underlying factors exacerbate uncertainty, unpredictability and disorganisation Work intensification and missed care

As noted earlier, an unexpected rise in patient volume is significant in increasing work intensity, and a consequence of this can lead to missed care. It is not surprising that heavy admissions are listed in the top five reasons for missed care for NSW, SA and Victoria given the NEAT rule. Research from NSW (Blackman et al. 2015a) indicates that the NEAT targets of 4 hours limit for patients in A&E can result in patients being assigned to a ward, often as an outlier. While we have yet to identify research that links missed care to outliers, it seems obvious that where nurses are not familiar with the patient's condition, missed care might occur. That it occurs in NZ is also to be expected

Rounding

A new finding for our MISSCARE surveys is the perception that rounding impacts on omission. This may indicate that rounding makes nurses more aware of omissions in care or alternately that the performance of rounding uses time that could be spent on other aspects of care delivery. The second option is contradictory, given it is a managerial strategy introduced in response to systemic disorganisation (Willis et al. 2015). Just over half the nurses who completed the survey said rounding was mandated in their hospital or ward (figure 3.27). Nurses who did not perform rounding reported that it was standard nursing practice, that bed to bed handover made it unnecessary, that it was not relevant to their context, eg in ICU, or they had no idea what it was. In chapter 4 we note that rounding was seen by nurses and midwives to be part of the competing demands, and that doing it, takes time away from other care tasks seen as a higher priority.

Comparing the public and private sectors

Table 5.4 takes the five major reasons for missed care cited by nurses working in the public and private sectors in Victoria and NSW. For New South Wales these findings were reinforced by the qualitative responses where nurses pointed to having to manage more

complex and older patients with multiple co-morbidities across all sectors as the main cause of heavier workloads. Nurses in the private sector and aged care point to the direct relationship between profits and staffing levels. In Victoria, ownership of facilities was not significantly related to missed care. Despite this, nurses working in the private sector gave inadequate staffing greater priority than nurses working in the public sector.

Table 5.4: Five top reasons for missed care in the public and private sectors in NSW and Victoria

New South Wales		Victoria	
Public	Private	Public	Private
Unexpected rise in patient volume and/or acuity on the ward/unit	Inadequate number of staff	Unexpected rise in patient volume and/or acuity on the ward/unit	Inadequate number of staff
Inadequate number of staff	Urgent patient situations (e.g. worsening patient condition)	Urgent patient situations (e.g. worsening patient condition)	Unexpected rise in patient volume and/or acuity on the ward/unit
Urgent patient situations (e.g. worsening patient condition)	Inadequate number of assistive and/or clerical personnel (e.g. care assistants, ward clerks)	Inadequate number of staff	Urgent patient situations (e.g. worsening patient condition)
Heavy admission and discharge activity	Unexpected rise in patient volume and/or acuity on the ward/unit	Heavy admission and discharge activity	Inadequate skill mix for your area
Inadequate number of assistive and/or clerical personnel (e.g. care assistants, ward clerks)	Unbalanced patient assignment	Inadequate skill mix for your area	Unbalanced patient assignment

Causes of missed care in Aged Care

Another group of nurses who identify a different experience of missed care are those working in aged care. Table 5.5 outlines the top five reasons for missed care in both aged care and in hospitals in New South Wales and Victoria. For the purpose of analysis, the hospital category includes all respondents who provide general nursing care within a hospitals environment and excludes midwives and mental health nurses.

Table 5.5: Top five reasons given why nursing care is missed in NSW and Victoria (aged care vs hospitals)

Aged care NSW	Hospitals NSW	Aged care Vic	Hospitals Vic
Inadequate no. of staff	Unexpected rise in patient acuity	Inadequate no. of staff	Unexpected rise in patient acuity
Urgent patient situation	Urgent patient situation	Urgent patient situation	Urgent patient situation
Inadequate no. of support staff	Inadequate no. of staff	Inadequate skillmix for the area	Heavy admission and discharge activity
Tensions or communication breakdown in the nursing team	Heavy admissions and discharges	Lack of support from team members	Inadequate no. of staff
Lack of support from team members	Inadequate no. of support staff	Inadequate handover from previous shift	Inadequate skillmix for the area

The results from hospital nurses reflect those identified by the population as a whole and focus upon factors which increase uncertainty. Nurses working in aged care identify number of staff as the primary reason for missed care however, communication and teamwork issues also contribute to care being omitted, Nurses in NSW highlight the role of poor communication within the nursing team along with lack of support from the nursing team as causes for missed care. This trend is evident in the sixth top response for nurses working aged care in NSW which was that the carer did not communicate that care was provided. Communication and teamwork were also highlighted by Victorian nurses working in aged care. In this care, lack of support from the nursing team and inadequate handover are implicated in missed care.

Skillmix: Is there an issue with Health Assistants?

Table 5.5 also highlights the role of skill mix as a perceived cause of missed care in Victoria. One of the intriguing aspects of the results is the identification of team work as an issue for nurses. While nurses and midwives in all jurisdictions made some negative comments on team work, the Victorian survey participants provided responses that gave more weight to team work as an issue in missed care. As we noted in chapter 2 Health Assistants/Assistants in Nursing (AiNs) are now part of the care landscape on all states in Australia. Health Assistants have been employed in some Victorian public hospitals since 2009. They work under the supervision and delegation of a RN and may be given direction by an EN, however as the enrolled nurse works under the supervision and delegation of the registered nurse, they are not able supervise or delegate nursing care to this level of worker. Health assistants mainly perform Activities of Daily Living (ADLs), simple documentation and ensuring a safe and clean environment (State Government of Victoria 2014c). An evaluation of the initial

trial showed high levels of patient and RN/EN satisfaction with the work of health assistants and notably team work was considered to be high. Health Assistants attend to patient mobility, toileting, feeding and assistance at meal time, patient hygiene, management of some of the resources, particularly replenishing, and bed making. Presumably a number of missed care items could be picked up by Health Assistants leading to less missed care. Results from this study suggests in contrast, that skillmix is viewed as contributing to missed care. This view is also reflected in responses to open questions with many nurses expressing concern with the employment of Health Assistants but few offering reasons for that concern.

Conclusion

This chapter has reviewed survey findings in light of the Victorian health care system. While results are inconclusive, there is some evidence that staffing is viewed as less likely to cause missed care by nurses working within the public sector in Victoria than it is in other states. Despite, this, staffing is still viewed as problematic, particularly when unexpected events occur which leave insufficient time for basic nursing care. Respondents from Victoria also cited greater issues with teamwork and communication than nurses in other jurisdictions, with teamwork identified as a direct cause of missed care in Victoria. This contrasts with responses from nurses in New South Wales and South Australia who cite workload unpredictability and resource issues as contributing to missed care (Blackman et al. 2015a; 2015b),

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Appendix A: MISSCARE Survey Victoria

Missed Nursing Care Survey Victoria

Thank you for participating in our survey. This survey will help us learn more about nurses' work environments and the care they provide, particularly in the period 'after hours', including weekends. Our questions focus specifically on the clinical setting and the shifts you may work during this time.

* 1. Do you currently work as a nurse and/or midwife in a clinical setting at least once each fortnight?

Yes

No

Missed Nursing Care Survey Victoria

About you

2. Gender

Female

Male

3. Age

Under 25 years old (<25)

25 to 34 (25-34)

35 to 44 (35- 44)

45 to 54 (45-54)

55 to 64 (55 - 64)

Over 65 years old (65+)

4. Do you work in a ...

Private setting

Public setting

For an Agency

* 5. Mark all that apply. Is your workplace located in a

- Large acute care hospital
- Large regional/remote acute care hospital
- Medium acute care hospital in a major city
- Medium acute care hospital in a regional area
- Small regional acute care hospital (small country towns)
- Small remote hospitals but not 'multi-purpose services'
- Small non acute hospital
- Multi-purpose service
- District Nursing Service
- Community Health Service
- Hospices
- Rehabilitation
- Other non-acute (e.g. geriatric treatment centres combining rehabilitation and palliative care with a small number of acute patients)
- Psychiatric
- Other hospitals/services (e.g. prison medical services, dental hospital)
- Residential Aged Care Facility

Other (please specify)

--

6. What is your main area of practice?

- Aged Care
- Community Health
- Critical Care/Intensive Care
- Education
- Family/Child Health
- Management/Administration
- Medical/Surgical
- Mental Health
- Midwifery
- Peri-operative
- Rehabilitation
- Research

Other (please specify)

7. Do you spend the majority of your working time in this area?

- Yes
- No

8. Is this your main job?

- Yes
- No

Other (please specify)

9. What is your highest qualification?

- Certificate III, Health Services/Nurse Assistant
- Enrolled Nurse Certificate (Hospital trained)
- Certificate IV, Enrolled Nurse
- Registered General Nurse Certificate
- EN Diploma in Nursing
- RN Diploma in Nursing or equivalent
- Bachelor Degree in Nursing
- Bachelor Degree in Midwifery
- Bachelor Degree/Honours outside of Nursing
- Graduate Diploma in Nursing/Midwifery
- Graduate Diploma outside of Nursing/Midwifery
- Master's degree in Nursing/Midwifery
- Master's degree outside of Nursing
- PhD/Professional Doctorate

Other (please specify)

10. Was your original nursing qualification from Australia?

- Yes
- No

If no, list country where you were first qualified as a nurse

11. Was your original Midwifery qualification from Australia?

- Yes
- No

If no, list country where you were first qualified as a nurse

12. Job Title/Role in the clinical area

- Health Assistant in Nursing (AIN)
- Enrolled Nurse
- Registered Nurse/Midwife
- Midwife only
- Clinical Nurse/Midwife Consultant
- Clinical Nurse Specialist or equivalent
- Nurse/Midwife Manager or equivalent
- Nurse Practitioner
- Practice Nurse
- Nursing Director or equivalent
- Director of Nursing
- Academic (e.g. Lecturer, Researcher)
- Personal Care Worker

Other (please specify)

13. Employment status when you work in the clinical area.

- Full-time permanent
- Part-time permanent
- Full-time casual
- Part-time casual
- Agency

Other (please specify)

14. Number of hours usually worked per week.

- less than 24 hours per week
- less than 30 hours per week
- 30 hours or more per week

15. Which of these categories best describes your rostered/scheduled work hours. Mark all that apply.

- All early or day shifts
- All late or evening shifts
- All night shifts
- Monday to Friday only
- Weekends only
- Rotating roster/shifts (morning, afternoon/evening and weekends)
- Rotating roster/shifts (morning, afternoon/evening, nights and weekends)
- Irregular schedule
- Split shifts (within the shift/day)
- On call

Other (please specify)

16. Would you prefer to maintain your current work schedule, or change it?

- Prefer to maintain current schedule
- Prefer to change to a different schedule

17. If you could change your current work pattern/roster, which would you prefer?

- Days (less than 8 hours)
- Evenings (less than 8 hours)
- Days (8 - 12 hour shift)
- Afternoon/Evening (8 - 12 hour shift)
- Nights (8 - 12 hour shift)
- 7 day roster
- 5 day roster (Monday to Friday only)
- Set rotating roster (e.g. 6 week rotation)
- Flexible working time rostering/scheduling
- Prefer to work longer hours/shifts

Briefly explain why you would change

18. Experience in your role

- 0- 6 months
- 7 months to 1 year
- 1 - 2 years
- 3 - 4 years
- 5 - 6 years
- 7 - 8 years
- 9 - 10 years
- 11 - 15 years
- 16 - 20 years
- Greater than 20 years

Other (please specify)

19. This question relates to the length of your working hours. How many hours will you usually work in a shift?

- Less than 4 hours
- 4 to 6 hours
- Greater than 6 hours to 10 hours
- Less than 10 hours to 12 hours

Other (please specify)

20. Thinking about the hours you are employed, how many times in the past 3 months did you work more than your rostered shift length?

- Less than 5 times
- 5-10 times
- 11-15 times
- 16-20 times
- Greater than 20 times
- Never

Other (please specify)

21. In the past 3 months how many hours of overtime did you work?

- Less than 5 hours
- 6 - 10 hours
- 11 - 15 hours
- 16 - 20 hours
- Greater than 20 hours
- Did not work overtime

Other (please specify)

22. In the past 3 months, how many rostered shifts did you NOT work because your were sick, injured and/or significantly fatigued.

- None
- 1 shift
- 2-3 shifts
- 4-6 shifts
- over 6 shifts

Comment

23. In the past 3 months how many shifts did you work even though you were sick, injured or significantly fatigued?

- None (Go to question 24)
- 1 shift
- 2-3 shifts
- 4-6 shifts
- over 6 shifts

Other (please specify)

24. Please mark all that apply. I worked while sick, injured or significantly fatigued because

- I did not have any leave left
- I felt an obligation to my colleagues
- We were short staffed
- I felt fit to work
- Financial reasons

Other (please specify)

25. In general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

26. How often do you feel your ward/Unit staffing is adequate?

- 100% of the time
- 75% of the time
- 50% of the time
- 25% of the time
- 0% of the time

27. On the last shift you worked, how many patients did you care for?

* 28. Does your organisation use a staffing tool? If so, what is it called? Please write name in the box below

- Yes
- No

Other (please specify)

29. In your opinion, does the staffing tool used in your organisation assist in preventing missed nursing care? If so, why? If not, why not? Please comment in the box below.

30. On the last shift you worked how many patient-admissions did you have (i.e. includes transfers into the Unit/ward)?

31. On the last shift you worked how many patient-discharges did you have (i.e. includes transfers out of the Unit/ward)?

32. How satisfied are you in your current position?

- Very satisfied
- Satisfied
- Dissatisfied
- Very dissatisfied

If dissatisfied, please specify where your dissatisfaction comes from:

33. How satisfied are you with the level of teamwork on your Unit/ward?

- Very satisfied
- Satisfied
- Dissatisfied
- Very dissatisfied

If dissatisfied, please specify where your dissatisfaction comes from:

34. Do you plan to leave your current position? If planning to leave, please indicate your reasons for leaving below.

- In the next 6 months
- In the next year
- No plans to leave

Other (please specify)

35. Independent of your current position/job, how satisfied are you with being a nurse/midwife?

- Very satisfied
- Satisfied
- Dissatisfied
- Very dissatisfied

Other (please specify)

Missed Nursing Care Survey Victoria

Managing care in your workplace

Healthcare organisations engage in a number of practices to ensure that quality nursing care is delivered by staff. Rounding is argued to be one such practice.

* 36. Do you do 'rounding' as part of your work?

- Yes
- No

* 37. How do you understand 'rounding' in the context of your workplace?

38. How frequently does your workplace expect you to conduct rounds?

- Half hourly
- Hourly
- As decided by you
- No specific requirement

Other (please specify)

* 39. How is rounding recorded in your workplace?

- Not recorded
- Recorded in a 'rounding chart' that is included in the medical record/casenotes
- Recorded in a 'rounding chart' that is NOT included in the medical record/casenotes
- Recorded elsewhere

Please specify where this is done

40. If you are charting or documenting 'rounds' what aspects of care are you recording?

* 41. In your opinion, how does 'rounding' contribute to quality patient care?

Nurses frequently encounter multiple demands on their time, which requires them to reset priorities and not accomplish all the care needed by their patients. To the best of your knowledge in the past three (3) months, how frequently are the following elements of nursing care MISSED (not done, omitted, left unfinished) by nursing staff (including you) on the shifts below. The times indicated in this section refer to the standard shift length times in your workplace. Early, late and nights worked Monday to Friday inclusive of weekends. Please mark all that apply.

42. Assit in ambulating three times a day or as ordered

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

43. Turning patient every 2 to 4 hours

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

44. Feeding patients while food is still warm

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

45. Assist with toileting needs within 5 minutes of request

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

46. Setting up meals for patients who feed themselves

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (please specify)

47. Vital signs taken as ordered

Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

48. Monitoring intake/output as ordered

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

49. Full documentation of all necessary nursing/midwifery interventions

Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

50. Patient education about illness, tests and diagnostic studies

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

51. Emotional support to patient and/or family

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

52. Patient Hygiene

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

53. Patient Oral Hygiene

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

54. Nurse Hand Hygiene

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

55. Skin/Wound Care

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

56. Patient discharge planning and education

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

57. Bedside glucose monitoring as ordered

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

58. Focused reassessments according to patient condition

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

59. IV access devices and assessments according to hospital policy

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

60. Response to call bell/light initiated within 5 minutes

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

61. PRN medication requests acted on within 15 minutes

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

62. Medications administered within 30 minutes before or after scheduled time

	Never missed	Rarely missed	Occasionally missed	Frequently missed	Always missed	N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

63. Assess effectiveness of medications

						N/A
Early or day shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late or evening shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night shift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

Missed Nursing Care Survey Victoria

SECTION B: REASONS FOR MISSED NURSING/MIDWIFERY CARE

64. Indicate the reasons that you believe contributes to MISSED care in your ward/Unit. Please mark one box for each item.

	Not a reason	Minor reason	Moderate reason	Significant reason	N/A
Inadequate number of staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inadequate skillmix for your area	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Urgent patient situations (e.g. deteriorating patient condition)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unexpected rise in patient volume and/or acuity on the ward/Unit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inadequate number of assistive and/or clerical personnel (e.g. care assistants, ward clerks, porters)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unbalanced patient assignment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medications not available when needed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inadequate handover from the previous shift or patient transfer into ward/Unit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Not a reason	Minor reason	Moderate reason	Significant reason	N/A
Other departments did not provide the care needed (e.g. physiotherapy did not ambulate)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supplies/equipment NOT available when needed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of back up support from team members	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tension or communication breakdowns with other ANCILLARY/SUPPORT DEPARTMENTS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tension or communication breakdowns within the NURSING/MIDWIFERY TEAM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tension or communication breakdowns with the MEDICAL STAFF	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nursing Assistant/Carer did or did not communicate that care was provided	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staff member assigned to the patient absent from ward/Unit or unavailable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heavy admission and discharge activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not able to access registered nurse in a timely manner OR registered nurse is unavailable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unable to access Information Technology (IT)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Not a reason	Minor reason	Moderate reason	Significant reason	N/A
Wearing Personal Protective Equipment (PPE) (e.g. working in Isolation Rooms and not being able to assess equipment, supplies, or assistance of another staff member to assist with care such as manual handling, complex procedures)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

Missed Nursing Care Survey Victoria

EXPERIENCING WORK: MISSING CARE

In this section we would like you to reflect upon how you manage to deliver care and some of the circumstances that may influence how you will do your work. How difficult or easy is it for you to do the following aspects of your work?

65. Work within your scope of practice

Extremely difficult for me	Difficult for me	Easy for me	Very easy for me	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (please specify)

66. Deliver care that is consistent with your own expectations of practice standards

Extremely difficult for me	Difficult for me	Easy for me	Very easy for me	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (please specify)

67. Deliver care that is consistent with your organisations practice standards

Extremely difficult for me	Difficult for me	Easy for me	Very easy for me	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (please specify)

68. Collaborate with other disciplines when planning and providing patient care

Extremely difficult for me	Difficult for me	Easy for me	Very easy for me	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (please specify)

69. Attend interdisciplinary care conferences whenever held

Extremely difficult for me	Difficult for me	Easy for me	Very easy for me	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (please specify)

70. Delegate work to other staff where appropriate

Extremely difficult for me	Difficult for me	Easy for me	Very easy for me	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (please specify)

71. To deliver uninterrupted nursing care

Extremely difficult for me Difficult for me Easy for me Very easy for me N/A

Other (please specify)

72. To be autonomous in how I deliver nursing care

Extremely difficult for me Difficult for me Easy for me Very easy for me N/A

Other (please specify)

73. Implement nursing care in the absence of policies/procedure guidelines

Extremely difficult for me Difficult for me Easy for me Very easy for me N/A

Other (please specify)

74. Is there anything else you would like to tell us about missed nursing care?

Missed Nursing Care Survey Victoria

THANK YOU

We appreciate your time. If you would like more information about the study you are welcome to contact

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