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Most ward nurses say time pressures force them to 'ration' care

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Most ward nurses say they are forced to ration care, and not do or complete certain aspects of it—including adequate monitoring of patients—because they don't have enough time, indicates research published online in *BMJ Quality & Safety*.

The lower the nurse headcount, the greater the risk, the study shows, prompting the researchers to suggest that hospitals could use episodes of missed care as an early warning sign that nurse staffing levels are too low to provide safe, high quality care.

They base their findings on a survey of almost 3000 registered nurses working in 401 general medical/surgical wards in 46 acute care NHS hospitals across England between January and September 2010.

The questions, which covered five different domains, were designed to gauge the prevalence of missed care—care that nurses deemed necessary, but which they were unable to do or complete because of insufficient time.

Thirteen different aspects of nursing care were included in the survey, ranging from adequate patient monitoring, through to adequate documentation of care, and pain management.

The researchers wanted to find out if there was any association between nurse staffing levels and the number of these episodes, and whether these were linked to overall perceptions of the quality of nursing care

and patient safety in a ward.

So they asked nurses to rate the quality of care on their ward, and to indicate how many patients needed assistance with routine activities and frequent monitoring. The researchers also assessed the quality of the working environment using a validated scoring system—the Practice Environment Scale (PES).

The results showed that 86% of the 2917 respondents said that at least one of the 13 care activities on their last shift had been needed, but not done, because of lack of time. On average, nurses were unable to do or complete four activities.

The most commonly rationed of these were comforting and talking to patients, reported by 66% of participating nurses; educating patients (52%); and developing or updating care plans (47%).

Pain management and treatment/procedures were the activities least likely to be missed, reported as not being done by only 7% and 11%, respectively.

Higher numbers of patients requiring assistance with routine daily living or frequent monitoring were linked to higher numbers of missed care activities.

Staffing levels varied considerably across wards, but the average number of patients per nurse was 7.8 on day shifts and 10.9 at night.

The fewer patients a nurse looked after, the less likely was care to be missed or rationed, and the lower was the volume of these episodes. Staffing levels were significantly associated with rationing eight of the 13 care activities.

Nurses looking after the most (in excess of 11) patients were twice as likely to say they rationed patient monitoring as those looking after the fewest (six or fewer). Adequate documentation and comforting/talking with patients also suffered the most.

Staffing levels of healthcare assistants had no bearing on rationing of care. But the quality of the work environment did, with the average number of care activities significantly lower (2.82) in the best than in the worst (5.61).

Around eight care activities were left undone on wards nurses rated as "failing" on patient safety, compared with around 2.5 on wards rated as "excellent."

"Our findings raise difficult questions for hospitals in a climate where many are looking to reduce—not increase—their expenditure on nurse staffing," comment the authors, who go on to say that hospitals would have to reduce the number of patients to seven or fewer per registered nurse to significantly reduce the amount of care left undone.

But they suggest: "Hospitals could use a nurse-rated assessment of "missed care" as an early warning measure to identify wards with inadequate nurse staffing."

More information: 'Care left undone' during nursing shifts: associations with workload and perceived quality of care, Online First, doi 10.1136/bmjqs-2012-001767

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