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REVIEW ARTICLE

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A scoping review—Missed nursing care in community healthcare contexts and how it is measured

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Abstract

Aim: To examine the extent and nature of missed nursing care in elderly care in community healthcare contexts from the perspective of healthcare staff, and to identify instruments used to measure missed nursing care and the content of these instruments.

Design: Scoping review.

Methods: Searches were conducted in the CINAHL, PubMed, Scopus and Google Scholar databases in March 2020. The selection process followed the PRISMA flow diagram.

Results: Sixteen research papers were found from nine countries. The instruments used in the studies were Basel Extent of Rationing of Nursing Care for nursing homes (BERNCA-NH), modified MISSCARE survey and study-specific instruments or items. The item content differed, as did the number of items, which was between one and 44. The studies reported values for missed nursing care, as well as described reasons for and/or the relation between missed nursing care and organization, working climate and patient outcomes.

KEYWORDS

community health care, elderly care, instrument, missed nursing care, scoping review

1 | INTRODUCTION

A study published in 2001, including nurses from five countries working in hospitals, reported that nursing tasks were left undone even though they were necessary (Aiken et al., 2001). Five years later, an interview study with nurses and nurse assistants working in hospitals described the phenomenon of missed nursing care, which did not consist of nursing care that can be missed in an acute situation or on a solitary occasion (Kalisch, 2006). Following these studies, additional research with similar concepts has been conducted. Research is widely conducted in acute care hospital settings (Jones et al., 2015), and the research in non-acute care is still scarce (Sworn & Booth, 2020).

There is an increasingly ageing population, which will lead to an increasing care dependency and need for social care (World Health Organisation, 2015). Nurses provide health care, especially in community healthcare contexts where they are often the first and only ones meeting the needs for health care (World Health Organisation, 2020). Countries all over the world face the challenge to reform their community health care to meet the needs of the ageing population (Amalberti et al., 2016). The definition and function of nurses in community health care differs between countries (Barrett et al., 2016). Therefore, it is of interest to examine the research area of missed nursing care in community health care.

2 | BACKGROUND

Missed nursing care is a deviation of omitted care, meaning that the care will not be done at all (errors of omission) or that it can be done but in an incorrect way (error of commission) (Kalisch et al., 2009), and ought to be seen as medical error (Jones et al., 2015). Nursing care that is not performed is related to negative consequences for patients, nurses and organizations (Jones et al., 2015) and can be seen as a threat to quality of care (Kalánková et al., 2019; Papastavrou et al., 2014) and patient safety (Kalánková, Žiaková, et al., 2019; Kalisch et al., 2009; Papastavrou et al., 2014; Simpson & Lyndon, 2017; Sworn & Booth, 2020). The more missed nursing care, the lower the staff´s perception of quality of care (Ball et al., 2014), quality of nursing care (Sochalski, 2004) and patient safety (Ball et al., 2014; Min et al., 2020; Sochalski, 2004). Healthcare complaints from patients show both errors of omission and commission (Gillespie & Reader, 2018). If there is a reduction in missed nursing care, the result should be an increase in patient satisfaction and a decrease in adverse events (Recio-Saucedo et al., 2018).

There are many different concepts used to describe nursing care rationing, and as of yet, there is no international consensus regarding which concept should be used (Kalánková, Žiaková, et al., 2019; Papastavrou et al., 2014), although the overall meaning of the concept missed nursing care is about nursing care not given to a patient (McNair et al., 2016). In the current research, the following concepts are used with a similar meaning: "missed care, care left undone, rationed care, unfinished care, delayed care, errors of omission, care omissions, and inadequate care" (Ogletree et al., 2020). Additionally, the following concepts are used to express a similar meaning: "missed nursing care, (nursing) care/tasks left undone, (implicit) rationing of nursing care, omission of care, omitted care, tasks incompletion, unmet nursing/care needs, and unmet patient need". In terms of content, the concepts are similar (Kalánková, Žiaková, et al., 2019), with most research using omission of care as delay or failure of care (Ogletree et al., 2020). In order to investigate the understanding of the concepts of missed care, rationed care and unfinished care, a questionnaire was sent out to researchers in 26 countries. Missed care was described as omitted care and mentioned about care not given, following a caring situation. Rationed care was about prioritization of nursing care, the decision to not give care was made before the situation. Unfinished care was about nursing tasks that had been initiated, but had not been completely done finished (Willis et al., 2020). Throughout this paper, the concept "missed nursing care" will be used, with some exceptions in which the used concept will be the same as in the referenced papers.

Instruments to measure missed nursing care have been developed and used in research. Kalisch and Williams (2009) designed and validated the instrument MISSCARE survey, which measures missed nursing care and its reasons, to be used in hospital contexts. Thereafter, increased interest has led to translation, modifications and validation of the instrument for use in different countries, such as Turkey (Kalisch et al., 2012), Iceland (Bragadóttir et al., 2015) and Brazil (Siqueira et al., 2017). In Switzerland, Schubert et al., (2007) developed and validated the instrument Basel Extent of Rationing of Nursing Care (BERNCA), for hospital contexts. The instrument have been developed for usage in nursing home settings (BERNCA-NH) (Zúñiga et al., 2015b, 2016).

In recent years, there has been increasing interest in research on missed nursing care. Former review papers have presented studies including hospital perspectives, (Bagnasco et al., 2020; Fitzgerald et al., 2020; Griffiths et al., 2018; Jones et al., 2015; Kalánková et al., 2019; Kalánková, Žiaková, et al., 2019; McCauley et al., 2020), both hospital and chronic clinical settings/nursing homes/primary care perspectives, (Kalánková et al., 2020; Mandal et al., 2020; Papastavrou et al., 2014; Recio-Saucedo et al., 2018; Sworn & Booth, 2020; Vincelette et al., 2019; Vryonides et al., 2015; Zhao et al., 2020) and patients´ perspectives (Gustafsson et al., 2020). Ludlow et al., (2021) had a residential aged care perspective, but also included studies with different settings and professions. Ogletree et al., (2020) studied definitions of omissions of care and adverse events in relation to omissions of care in nursing homes. Despite this increasing interest, there has been little research in community healthcare contexts, with focus on the instruments and the content of the instruments. Measuring missed nursing care with regular time intervals can be one strategy to improve patient safety and quality of care (Palese et al., 2019). Based on this knowledge, it becomes even more important to examine research conducted in nursing from a community healthcare perspective, with focus on all care staff, and regardless of the organization. Thus, the aim of this scoping review was to examine the extent and nature of missed nursing care in elderly care in community healthcare contexts from the perspective of healthcare staff. A further aim was to identify instruments used to measure missed nursing care and the content of the instruments.

3 | THE STUDY

3.1 | Design

A scoping review is to map key concepts and examine studies in a research area to give an overview of the extent and nature of the current literature (Arksey & O'Malley, 2005). In this study, the first five stages described by Arksey and O'Malley (2005) were used. The stages are as follows: (a) identifying the research question, (b) identifying relevant studies, (c) study selection, (d) charting data and (e) collating, summarizing and reporting the results. Clarifying recommendations from Levac et al., (2010) were used: the purpose and research question were linked together, a team of researcher selected and extracted data, a numerical result as well as a thematic analysis was performed, identifying implications for practice, and research was presented. A quality appraisal was added, as recommended by Daudt et al., (2013), to ensure the scientific quality of the included papers, following Polit and Beck (2017) protocols.

3.2 | Methods

3.2.1 | Stage 1—Identifying the research question

In order to examine the extent and natsure of missed nursing care and to identify related instruments, following research questions were identified:

1. What characterized the studies in the area?
2. How was missed nursing care measured?
3. What was the content of the identified instruments and questions?
4. Are the identified instruments validated, and if so, how?
5. What were the main findings of the studies?

3.2.2 | Stage 2—Identifying relevant studies

The initial searches were conducted in August 2019, in CINAHL, PubMed and Scopus databases, to identify studies that answered the research questions. The concept missed nursing care has no thesaurus term (indexed word) in the databases, so relevant search terms were identified by reading papers in the subject area, and with the help of a university librarian who has expert knowledge of database searches in nursing. Several keywords and phrases were used with truncations and Boolean operator (OR). Limitations in all searches were English language and peer-reviewed. No limitations for publication year were set. The first searches resulted in 2,714 papers, see Table 1.

Supplementary searches were conducted in March 2020 using the same databases and search words as before. In addition, a search was conducted in Google Scholar, in the same manner as for the other databases. A manual search in the included papers´ references and in key journals was conducted to ensure that no papers were missed. These additional searches yielded six more papers.

3.2.3 | Stage 3—Study selection

Study selection was based on the following inclusion criteria: the context of the empirical studies was care of elderly people in nursing homes or community health care in which the respondents were assistant healthcare workers (or similar), enrolled nurses or registered nurses. The selection process followed PRISMA flow diagram (Moher et al., 2010), see Figure 1.

The data were systematically collected and sorted. A first sorting of duplicates was done in the reference management software EndNote, thereafter followed a manual sorting. A total of 1,229 duplicates were found. The remaining 1,485 titles and/or abstracts were exported to the web application Rayyan (Ouzzani et al., 2016). In order to identify papers that seemed to meet the research questions and criteria, the first author (IA) screened all of the titles and/or abstracts of the papers, and authors (CB), (JN), and (AJE) screened a third each, so all titles and/or abstracts were read and assessed by at least two authors. After screening the titles and/or abstracts, the authors´ opinions were compiled, if authors differed in their opinions, discussions were held until consensus was reached.

Fifty papers were chosen and read in full text by the first author (IA), and the other authors read a third each. A total of 39 papers were excluded because they did not answer the research questions. Finally, the process resulted in 16 papers included in this study, of which 14 had a quantitative design and two had a quantitative and qualitative design.

Quality appraisal was conducted on the papers according to the Guide to an Overall Critique of a Quantitative/Qualitative Research Report (Polit & Beck, 2017). The quality appraisals were first conducted individually by each of the authors and then discussed, in order to reach consensus regarding which papers fulfilled the quality requirements. The qualitative parts of the two studies with both quantitative and qualitative methods were excluded from the result following the quality appraisal.

3.3 | Analysis

3.3.1 | Stage 4—Charting data

The process of charting the data followed Arksey and O´Malley´s (2005) fourth stage including the following topics: authors, publication year, country, population, purpose, methodology, outcome measures and main findings relevant for this scoping review, see Table 2.

TABLE 1 The search process in CINAHL, PubMed and Scopus databases 2019–08–20

Search words	Hits
"Missed care" OR "Missed nursing care" OR "Care left undone" OR "Nursing care left undone" OR "Nursing task* left undone" OR "Rationing of nursing care" OR "Implicit rationing of nursing care" OR "Rationed care" OR "Unfinished care" OR "Omission of care" OR "Omitted care" OR "Delayed care" OR "Error* of omission*" OR "Task* incomple*" OR "Unmet care need*" OR "Unmet nursing need*" OR "Unmet nursing care need*" OR "Unmet patient* need*"	CINAHL: 555 PubMed: 908 Scopus: 1,251
Total	2,714

Note: Limitations CINAHL: English, peer review, all text, PubMed: English, titles/abstract, Scopus: English, articles.

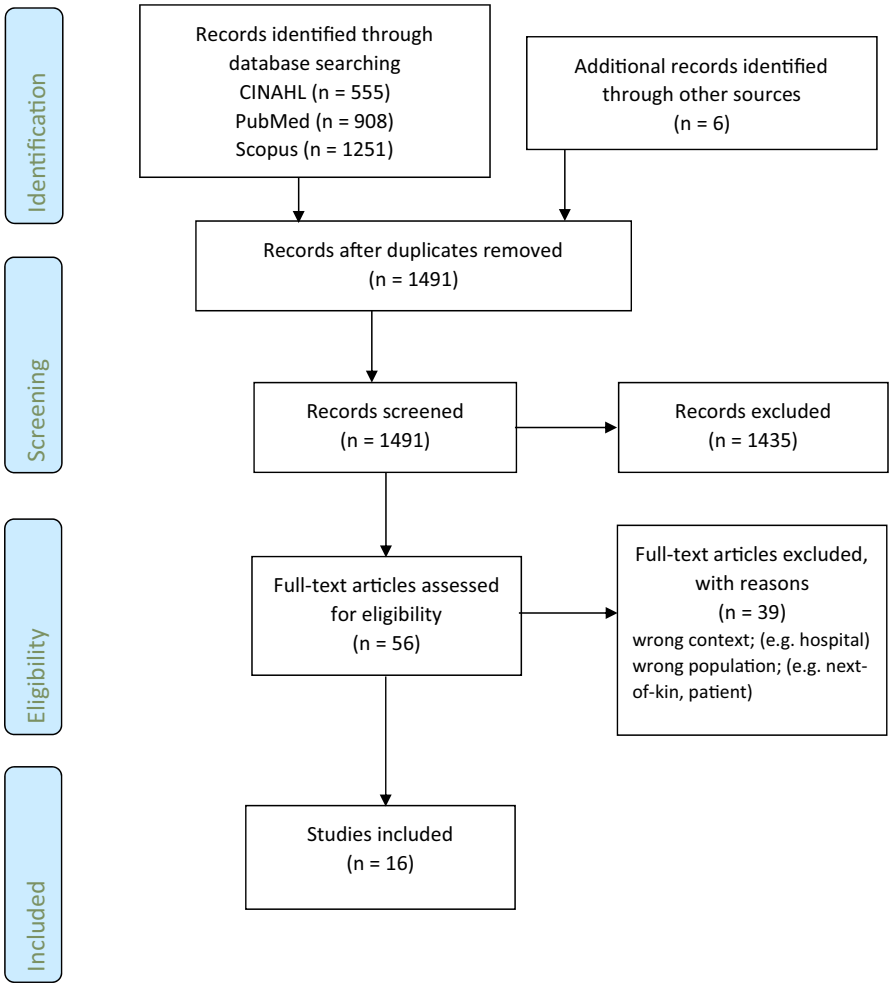

FIGURE 1 The PRISMA flow diagram. From: Moher et al., 2009

3.3.2 | Stage 5—Collating, summarizing and reporting the results

In the fifth and final stage, the answers to the research questions in the selected papers were collated, summarized and both numerical and thematic results were reported in a narrative, thematic organization according to Arksey and O'Malley (2005) and Levac et al., (2010), as shown in the results.

4 | RESULTS

The results in this scoping review are based on 16 papers with quantitative method, see Table 2, and are presented as numerical and thematic findings.

4.1 | Numerical findings

The answers to research questions 1–4 are presented in the text, tables and figures below.

4.1.1 | What characterized the studies in the area?

The included studies were performed in elderly care in community healthcare contexts with nursing care staff as participants, see Table 3. The number of participants in the studies ranged from $n = 264$ to $n = 4,847$. All studies were based on the staffs´ self-reported missed nursing care, with one exception where registered nurses reported enrolled nurses´ missed nursing care.

The studies were published between the years 2015 and 2020 and performed in nine countries. Four of the papers derived from two previously conducted studies, using data from the same data collection. Nine of the studies were parts of larger research studies, see Table 2.

4.1.2 | How was missed nursing care measured?

Developed instruments were used in ten studies for measuring missed nursing care, in their original format or with adaptions/modifications. There were also study-specific questionnaires developed by researchers used in six studies. The content of the items in the

instruments differed, as did the number of items, which were between 1–44, see Table 4. Table 5 presents all items from the studies grouped into concepts of missed care activities.

4.1.3 | What was the content of the identified instruments and questions?

Some of the studies reported values at an item level for missed nursing care. The group of items that had the highest reports of often missed care were communication, emotional support and counselling. Contrarily, the group of items that was never reported missed related to nutrition, see Figure 2. Other studies only reported values of missed nursing care, from a general perspective, and some studies did not report any values of missed nursing care at all. All values reported "often" and "never" are presented in Table 5.

4.1.4 | Are the identified instruments validated, and if so, how?

Chronbach´s alpha and other means of validation were reported in some of the studies, and some studies did not account for any validation of the questions of missed nursing care, see Table 6.

4.2 | Thematic findings

The last research question "What were the main findings of the studies?" were answered in three themes describing reasons and/or the relation between missed nursing care and organization, working climate and patient outcomes. In some studies, reasons for missed nursing care were included: it could be either as a starting point for the questionnaire, as a part measured by the instrument or measured with a separate instrument alongside with other instruments.

4.2.1 | Missed nursing care are related to the organization, staffing and material insufficiencies

Nursing homes with fewer than 20 beds (Blackman et al., 2020) or 80 beds were related to more reported missed nursing care (Knopp-Sihota et al., 2015) when ownership was governmental (Blackman et al., 2020). Staff in private for-profit facilities reported more missed care than staff working in governmental facilities. Staff from the governmental facilities were less likely to cite a reason for missed nursing care than staff working in private facilities (Henderson et al., 2018). Working the day shift showed a significant association with reporting missed nursing care (Knopp-Sihota et al., 2015), and the reports on what care were missed differed between working the day and evening shifts (Henderson et al., 2017; Senek et al., 2020). The number of extra shifts staff worked were related to more reported missed nursing care (Blackman et al., 2020).

Staffs´ experiences of lack of time (Knopp-Sihota et al., 2015; Senek et al., 2020; Song et al., 2020; White et al., 2019; Zúñiga et al., 2015a, 2015b) or high workload (Zúñiga et al., 2015a, 2015b) caused or were related to more missed nursing care. Lack of resources (White et al., 2019), such as in staffing (Blackman et al., 2019; Henderson et al., ,,,2017, 2018; Senek et al., 2020; Tou et al., 2020; Zúñiga et al., 2015b) or incorrect use of staff (Henderson et al., 2018; Song et al., 2020), was reason for missed nursing care. Uneven resident allocation or too many residents with complex needs (Henderson et al., 2018), unexpected rise in patient volume or acuity, heavy admission and discharge duties were also reported as reasons (Henderson et al., 2017). Insufficiencies of material resources were also reported as a reason for missed nursing care (Tou et al., 2020).

4.2.2 | Missed nursing care are related to working climate and staff issues

The work environment had an impact on the occurrence of missed nursing care (Knopp-Sihota et al., 2015; White et al., 2019; Zúñiga et al., 2015b), with factors such as teamwork (Blackman et al., 2019), communication in the team (Tou et al., 2020), work stressors (Zúñiga et al., 2015b), culture and social capital (Song et al., 2020). Better teamwork and safety climate were related with more missed nursing care (Zúñiga et al., 2015b).

A higher level of missed nursing care was reported from staff that experienced job dissatisfaction (Blackman et al., 2020; White et al., 2019), bullying (Hogh et al., 2018) and/or burnout (Knopp-Sihota et al., 2015). Staff reporting not feeling mentally well also reported more missed care (Dhaini et al., 2017; Henderson et al., 2017). The same was shown for staff reporting not feeling physically well and with presenteeism, more missed nursing care occurred (Dhaini et al., 2017). Staff younger than 30 (Knopp-Sihota et al., 2015) or 34 (Phelan et al., 2018) reported more missed care than older staff. Studies that compared different regions could see that it mattered for levels of missed care (Knopp-Sihota et al., 2015; Phelan et al., 2018).

4.2.3 | Missed nursing care can have an impact on the elderly

When care was missed, such as failure to administer medications on time and failure to provide adequate patient surveillance, it showed significant association with occurrence of urinary tract infections among the residents (Nelson & Flynn, 2015). When the staff´s rationing of nursing care was less, their perception of quality of care increased (Zúñiga et al., 2015a).

TABLE 2 Matrix - Included papers

Authors, year, country	Aim	Method, population
Blackman et al., 2020, Australia	• Seeks to reliably align the different components of the missed care survey to three contemporary factors that are thought to underpin contemporary aged care nursing practices. This will identify the types and frequencies of missed care. • To identify the demographic factors that serve to be antecedents or have predictive qualities as to how missed residential aged care is expressed in the Australian setting.	• Quantitative • Response rate: • *N* = 2,467 care workers, enrolled nurses, registered nurses and nurse practitioners employed in aged care settings
Dhaini et al., 2017, Switzerland	• To assess the prevalence of implicit rationing of direct resident care, including rationing of activities of daily living and of caring, rehabilitation, and monitoring. • To explore the relationship between care workers´ health and presenteeism regarding implicit rationing of care.	• Quantitative, cross-sectional • Sub-study • Response rate: • *N* = 3,239 registered nurses, licensed practical nurses, certified assistant nurses, and nurse aides from 162 randomly selected nursing homes
Henderson et al., 2018, Australia	• To compare and contrast perceptions of the frequency and causes of missed care as reported by nursing and personal care workers in government, private-not-profit and for-profit residential aged care facilities in Australia.	• Quantitative, cross-sectional • Part of a larger study • Response rate: • *N* = 3,206 registered nurses, enrolled nurses, and personal care workers in residential aged care
Henderson et al., 2017, Australia	• To explore perceptions of the frequency and causes of missed care in residential aged care.	• Quantitative, cross-sectional • Part of a larger study • Response rate: • *N* = 922 registered nurses, enrolled nurses and personal care assistants in residential aged care
Hogh et al., 2018, Denmark	• Will investigate the impact of bullying (T1) on missed nursing care and quality of care 2 years later (T2) using a large sample of healthcare providers in the eldercare sector and to test the potential mediating effect of affective organizational commitment.	• Prospective cohort study with 2 years between T1 and T2 • Response rate: • *N* = 4,000 healthcare providers in the eldercare service
Knopp-Sihota et al., 2015, Canada	• To describe the nature and frequency of rushed or missed care by healthcare aides in western Canadian nursing homes. • To assess the association of rushed or missed care with care aide characteristics.	• Quantitative, cross-sectional • Part of a larger study • Response rate: • *N* = 583 healthcare aides working in nursing homes
Nelson & Flynn, 2015, USA	• To describe the frequencies and types of missed nursing care in nursing homes, and to determine the relationship between missed care and adverse event patient outcomes, as measured by the prevalence of urinary tract infections [UTI], among nursing homes residents. • To explore the specific types of missed nursing care activities that are most strongly related to the occurrences of UTIs among nursing home residents.	• Quantitative, cross-sectional • Secondary analysis • Response rate: • *N* = 340 registered nurses in nursing homes

Instrument	Main result
• Demographic, 29 items • Modified MISSCARE Survey, 27 items • Reasons for missed care, 27 items • Open-ended, 1 item	• Frequency of missed care related to the dimension maintaining residents´ health is affected by profession and the number of extra shifts. • The public-owned facilities and those with a size of <20 beds influenced the frequency of missed care to the dimension maximising the residents´ life potential. • Missed care, in the dimension relieving residents´ distress, is influenced by a number of factors, e.g. team working, adequate staffing, size, and ownership. It is more common in larger-sized residential facilities where staffing is seen as too low and a higher feeling of job dissatisfaction regarding teamwork.
• Socio-demographics • Basel Extent of Rationing of Nursing Care for Nursing homes, 19 items • Physical health factors, 3 items • Mental health factors, 3 items • Presenteeism, numbers of days • Work environment, 2 sub-scales	• 66% reported never rationing activities for daily living and 42.7 per cent never rationed caring, rehabilitation, and monitoring. • 24.9%–77%s reported never rationing of nursing care. • 0.9%–9.2% reported often rationing of nursing care. • The care workers health factors: joint pain, tiredness, headache, and emotional exhaustion, showed a significant relation to the items in sub-scales implicit rationing of activities for daily living, as well as caring, rehabilitation and monitoring. • Presenteeism showed a significant relation to implicit rationing of activities for daily living.
• Demographic and workplace, 28 items • Modified MISSCARE survey, 37 items • Reasons for missed care, 1 item (to rank 27 items) • open-ended, 1 item	• The nurses in the for-profit sector reported most missed nursing care and the nurses in the public sector reported least missed nursing care. • Most common tasks to miss were: move resident that can´t walk from bed to chair, assist visit to the toilet in 5 min, oral care, assessment of skin, and answering an alarm bell within 5 min. All with significant differences and private sector more often reporting. • The nurses in the private sector were more likely to cite a factor as a reason for missed nursing care, than the nurses in the public sector. • Most common reasons were: too few staff, too many residents with complex needs, inadequate staffing in order to competence, unbalanced resident allocation.
• Demographic and workplace, 28 items • Modified MISSCARE survey, 37 items • Reasons for missed care, 1 item • Open-ended, 1 item	• During the daytime, the most reported missed nursing care were: responding to call bells, toileting residents within 5 min of a request, and ambulating with residents. • During late shift, the most reported missed nursing care were: ambulating residents and patient education. • The reasons reported for missed nursing care differed between the regions. The most common, in general, were lack of staff, unexpected rise in patient volume or acuity, lack of assistive and clerical staff, heavy admission and discharge activity.
• Exposure to bullying, 1 item • Missed nursing care, 2 items • Quality of care, 6 items • Affective organizational commitment, 4 items • Demographic questions	• There is significant association between those who reported having been bullied, as they also report higher levels of missed nursing care. • Affective organizational commitment did not mediate the association between bullying and missed nursing care or quality of care.
• Demographic, 4 items • Job and vocational satisfaction, 2 items • Mental and physical health status, 8 items • Burnout, 9 items • Organizational context • work-related, 10 concepts with 3–9 items • Times felt rushed, 8 items • MISSED resident care, 10 items	• Lack of time was the reason for 75% to report leaving at least one care task missed last shift. • Most frequently missed were: talking with residents (52%), assisting with mobility (51%), nail care (35%), mouth care (19%), toileting (16%), hair care (14%), bathing (13%). • The healthcare aides that showed significant association with reporting most missed care were younger, worked in a specific region, worked on the day shift, worked in nursing homes with 35–79 beds, reported more burnout, were less effective, reported worse self-reported physical and psychological health, and were less satisfied with the work place and the organization.
• Missed nursing care, 12 items • Workload, 4 items	• At least one necessary care activity was missed during last shift, reported 48.2% of the nurses. • The most common missed care activities were comforting/talking with patients, developing or updating nursing care plans, teaching patients and families, documenting nursing care, and patient surveillance. • Missed care that had a significant association with UTI where residents had a catheter, were the failure to administer medications on time and the failure to provide adequate patient surveillance.

(Continues)

TABLE 2 (Continued)

Authors, year, country	Aim	Method, population
Norman & Sjetne, 2019, Norway	• To adapt and modify a Norwegian version of the Basel Extent of Rationing of Nursing Care for Nursing Homes [BERNCA-NH] intended to be applicable in a Norwegian nursing home setting.	• Quantitative, cross-sectional • response rate: • *N* = 931 care workers in nursing homes
Phelan et al., 2018, Ireland	• To examine the prevalence rates of missed care in the community nursing sector.	• Quantitative, Cross-sectional • Response rate: • *N* = 283 Public Health nurses [PHN] and Community Registered General Nurses [CRGN]
Senek et al., 2020, UK	• Prevalence of care left undone ad its relationship to levels of registered nursing staff within the community care, primary care, and care home setting.	• Cross-sectional • Secondary analysis • Response rate: • *N* = 3,009; registered nurses in care homes (1,267), community staff nurses (991), district nurses (433), practice nurses (318)
Song et al., 2020, Canada	• Examined how modifiable elements of organizational context are associated with missed and rushed care by care aides in nursing homes.	• Cross-sectional • Response rate: • *N* = 4,016 care aides in nursing homes
Tou et al., 2020, Taiwan	• To explore the frequencies and reasons for missed care and the correlation between missed care and the characteristics of nursing aides and long-term care facilities.	• Cross-sectional • Response rate: • *N* = 274; 184 nursing aides and 80 registered nurses working in nursing homes reporting nursing aides missed care
White et al., 2019, USA	• Examining how burnout and job dissatisfaction contribute to the likelihood of nursing home registered nurses leaving necessary care undone.	• Quantitative, cross-sectional • Secondary analysis • Response rate: • *N* = 687 registered nurses working with direct care in nursing homes
Zúñiga et al., 2015a, Switzerland	• To describe care workers reported quality of care and to examine its relationship with staffing, work environment characteristics, work stressors, and implicit rationing of nursing care.	• Quantitative, cross-sectional • Sub-study • Response rate: • *N* = 4,311 care workers in nursing home facilities
Zúñiga et al., 2015b, Switzerland	• To describe levels and patterns of self-reported implicit rationing of care in Swiss nursing homes. • To explore the relationship between staffing level, turnover, and work environment factors and implicit rationing of nursing care.	• Quantitative, cross-sectional • Sub-study • Response rate: • *N* = 4,307 care workers in nursing home facilities

Instrument	Main result
• Norwegian version of BERNCA-NH, 20 items • Care environment • Patient safety • Global ratings (quality of care, job satisfaction, recommend the unit as a workplace) • Demographic	• The test of the instrument showed good psychometric properties. • Leave a patient in urine/stool longer than 30 min (55.1%) and provide food other than regular meals (54.4%) are the two items which range highest for never been missed. • Activity that she/he wanted (32.3%) and studying care plans at the beginning of the shift (26.1%) are the two items which range highest for most often to be missed.
• Missed nursing care, inspired by MISSCARE, 64 items; 44 items as key components, and 20 items related to child care • Factors affecting missed care, 3 items • Demographic • Open-ended, 1 item (8 items about missed care in context older people)	• Maintaining "at risk register" was reported missed by 70.7% and health promotion for older people was reported missed by 73.5%. • Three tasks related to older people were reported missed: follow-up 62.6%, screening 58.6%, and follow-up dementia 57.1%. • Follow-up with dementia was seen with a significance of more missed care for nurses aged 35–44 • There was a significance related to which region the nurses worked in and maintaining elderly at risk register
• Nurse staffing levels, 2 items • Care left undone, 1 item • Type of shift, 1 item	• Community staff nurses and district nurses report respectively 39% and 37.3% missed care when reporting to be understaffed. When fully-staffed, the reporting is 23.5% and 22.1%. • Day shifts showed a significant correlation for reported care left undone related to full staff in nursing homes. • Reported care left undone in nursing homes when understaffed: day shift 52.5%, night shift 33.2%, and when fully-staffed: day shift 28.4%, night shift 35.6% in care homes. • Reported no care left undone when understaffed day shift 27.8%, night shift 35.6% and when fully staffed day shift 49.6%, night shift 49.8% in care homes.
• 10 elements of organizational context (2–9 items per element) • Rushed care, 7 items • Missed care, 8 items	• 57.4% care aides reported at least one care task missed, where taking residents for a walk (37.2%) being the most common. • 59% were less likely to miss care in a more favourable organizational context. • Missed care was associated with: culture, social capital, incorrect use of staff, and time.
• Missed nursing care, inspired by MISSCARE, 42 items; 26 items missed care, 16 items reasons for missed care • Demographic	• Most reported (occasionally, often, always) missed care was assistance with body cleaning (30.4%). Thereafter followed reminding to or assistance with hand cleaning (22.7%), and assistance with rehabilitation activities (22.4%). • Reasons reported for missed care were poor communication (90.2%), staff shortage (89.9%), and material resource insufficiencies (64.0%). • Participants that perceived too low staffing showed a significance to reporting more missed nursing care.
• Burnout, 9 items • Job dissatisfaction • Missed care, 15 items • Demographics	• Care most often missed was: comforting/talking with patients (50%), surveillance (c. 28%), teaching/counselling (c. 28%), and developing/updating care plans (c.28%). • Registered nurses reported missing, one or more care tasks, due to lack of time or resources on their last shift (72%). • Significantly higher rates for missed care if registered nurses felt job dissatisfaction and/or burnout.
• Quality of care, 1 item • Basel Extent of Rationing of Nursing Care adapted for nursing homes [BERNCA-NH], 19 items • Health Professions Stress Inventory, 12 items • Safety Attitude Questionnaire, 10 items • Practice Environment Scale–Nurse Working Leadership, 8 items - Demographics	• Rationing of nursing care was significantly related to perceived quality of care. • The odds for better quality of care increased with less rationing of caring, rehabilitation and monitoring and less rationing of social contacts. • More rationing of documentation increased the odds for higher quality of care.
• Basel Extent of Rationing of Nursing Care adapted for nursing homes [BERNCA-NH], 19 items • Practice Environment Scale–Nurse Working Leadership, • Safety Attitude Questionnaire, 10 items • Health Professions Stress Inventory, 12 items • demographics	• The care most often reported rationed were studying of care plans (13.4%) keeping residents who had rung waiting for more than five minutes (9.1%), carrying out social care (7.5%–11.9%). • The care that was least reported to been rationed were assistance with drinking (76.8%) and food intake (73.8%). • Work environment factors as; perception of lower staffing resources, teamwork, safety climate, and higher work stressors were significantly related with implicit rationing of nursing care.

(Continues)

TABLE 2 (Continued)

Authors, year, country	Aim	Method, population
Zúñiga et al., 2016, Switzerland	• To describe the development of the nursing home version of the Basel Extent of Rationing of Nursing Care [BERNCA]. • To provide initial evidence for validity based on test content, response processes and internal structure and evidence for reliability based on inter-scorer differences and inter-item inconsistencies for the German, French, and Italian-language versions of the BERNCA-NH.	• Development and testing BERNCA-NH in three phases • Adaption and translation • Content validity testing • Examining aspects of its validity and reliability • Data from Swiss Nursing Homes Human Resources Project (SHURP) • response rate: • $n = 4,847$

TABLE 3 Reported settings and participants in the studies

	Settings				
	Nursing homes/ unit	Care homes/ Personal care homes	Residential aged care facilities/ Residential long-term care Healthcare settings in residential aged care	Rehabilitation facility	Elder care sector in municipalities or communities
Blackman et al. (2020)			x		
Dhaini et al. (2017)	x				
Henderson et al. (2018)			x		
Henderson et al. (2017)			x		
Hogh et al. (2018)	x			x	x
Knopp-Sihota et al. (2015)	x	x	x		
Nelson and Flynn (2015)	x				
Norman and Sjetne (2019)	x				
Phelan et al. (2018)					x
Senek et al. (2020)	x				x
Song et al. (2020)	x				
Tou et al. (2020)	x				
White et al. (2019)	x				
Zúñiga et al. (2015a)	x				
Zúñiga et al. (2015b)	x				
Zúñiga et al. (2016)	x				

[a]Registered nurses reported missing care related to nursing aide duty.

Instrument	Main result
• BERNCA-NH, 19 items	• The overall result show that all three language give a valid and reliable instrument. • In all three regions assist food intake (76.0%–82.8%) and assist drinking (76.7%–82.3%) were the care most reported never rationed. • In the German speaking regions studying care plans at the beginning of shift (12.6%), and setting up or updating residents´ care plan (12.3%) were the care reported most often rationed • In the French speaking regions studying care plans at the beginning of shift (20.0%) and keeping residents waiting who rung (15.3%) were the care reported most often rationed. • In the Italian speaking regions scheduled individual activities (18.9%), and cultural activities (15.9%) were the care reported most often rationed.

Participants								
Registered nurses	Licensed practical nurses	Enrolled nurses	Certified assistant nurses	Nurse practitioners/ Practical nurses	Assistant nurses/ Nurse aides/Nurse assistants/Personal care assistants	Healthcare aides/Care aides	Personal care workers/ Personal support workers	Social and healthcare assistants/helpers
x		x		x			x	
x	x		x		x			
x		x					x	
x		x					x	
x					x			x
					x	x	x	
x								
x				x	x			
x								
x								
						x		
x[a]					x			
x								
x	x		x		x			
x	x		x		x			
x	x				x			

TABLE 4 Instruments and grouped content of missed nursing care

Instrument (number of items)	Number of options to answer	References	Hygiene	Nutrition	Assisting toileting needs	Sleepings	Mobilization, rehabilitation, social/cultural activity	Communication, emotional support, counselling
Basel Extent of Rationing of Nursing Care for Nursing Homes;6 BERNCA-NH (13)	5†	Dhaini et al. (2017)	x	x	x		x	x
BERNCA-NH (19)‡	5†	Zúñiga et al. (2015a)	x	x	x		x	x
BERNCA-NH (19)	6§	Zúñiga et al. (2015b)	x	x	x		x	x
BERNCA-NH (19)	6§	Zúñiga et al. (2016)	x	x	x		x	x
Adapted & modified BERNCA-NH (20)	6§	Norman and Sjetne (2019)	x	x	x		x	x
MISSCARE framework (27/37)¶	5	Blackman et al. (2020)	x	x	x		x	x
Modified MISSCARE (37/38)	5	Henderson et al. (2018)	x	x	x		x	x
Modified MISSCARE (37/38)	5	Henderson et al. (2017)	x	x	x		x	x
Modified MISSCARE (26)	6¥	Tou et al. (2020)	x	x	x		x	x
Inspired by MISSCARE (44, whereof 8 related to elderly people) ‡	6¥	Phelan et al. (2018)						x
Study-specific (10)	2	Knopp-Sihota et al. (2015)	x	x	x	x	x	x
Refers to instrument developed in previous studies (15)	2	Song et al. (2020)	x	x	x	x	x	x
Refers to instrument developed in previous studies (15)	-	White et al. (2019)	x				x	x
Refers to instrument developed in previous studies (12)	-	Nelson and Flynn (2015)	x					x
Study-specific (2)	5	Hogh et al. (2018)						
Study-specific (1)	5	Senek et al. (2020)						

†Likert scale; 0 = "activity was not necessary", 1 = never to 4 = often

‡All items in the instrument were not reported

§4-point Likert scale, and "activity was not necessary", one item: "not within my field of responsibility"

¶Number of items according to method/number of items reported in the results

¥5-point Likert scale, or "not applicable to my current caseload"/"not required"

5 | DISCUSSION

This scoping review has examined 16 papers related to missed nursing care in elderly care in community healthcare contexts from the healthcare staffs´ perspective in order to see what characterized the studies and what the main findings were. Some of the 16 papers included are from the same data collection, so twelve different studies were found to match this study´s criterion. This paper has identified instruments and the content of the instruments used to measure missed nursing care. The result shows that research on missed nursing care in community healthcare contexts is relatively new, from the 2015s onwards, and is going on all over the world. There are differences in settings and participants: in contexts, and numbers and in professions. The organization of community health care differs between countries, but all countries have some kind of health care for the elderly that takes place outside of the hospitals. There are cultural and organizational differences between different countries, but the elderly's need for out-of-hospital care will be found

Participation, dignity	Monitoring, surveillance	Responding to call bells	Pain management, administration of medication on time	Ordered treatments and procedures	Studying care plans, documentation, care planning	Intervening bad behaviour	Staff´s personal hygiene	General
	x							
	x				x			
	x	x			x			
	x	x						
	x	x	x	x	x			
x	x	x	x	x	x	x	x	
x	x	x	x	x	x	x	x	
x	x	x	x	x	x	x	x	
	x	x	x		x			
				x				
	x		x	x	x			x
	x		x	x	x			
								x
								x

regardless of the country. In this way, a comparison is still possible, taking into account these differences.

Different instruments are used to measure missed nursing care, and the content of these differs. Not all studies declare validation for used instrument. The original instrument, BERNCA-NH, is used and reported in four papers (Dhaini et al., 2017; Zúñiga et al., 2015a, 2015b, 2016), and all are from the same data collection. BERNCA-NH is also used in an adapted and modified form (Norman & Sjetne, 2019) to fit the Norwegian context. The instrument MISSCARE is modified to fit the context (Blackman et al., 2020; Henderson et al., ,2017, 2018; Phelan et al., 2018; Tou et al., 2020), and two of the included papers are from the same study. There is no mutually used instrument for measuring missed nursing care, probably because of differences in organizations between countries. This result in that only identical single items will be possible to compare between studies (Norman & Sjetne, 2019). The care processes differ between settings, and in order to measure what is relevant for the specific setting, an adaption and/or

TABLE 5 Reported content of items of missed nursing care, grouped and with values in per cent, for often occurring/happening that nursing care was missed and never missed nursing care

ITEMS	VALUES[a]	REFERENCES
Hygiene		
Sponge bath/skin care	Often 2.1 Never 54.6	Dhaini et al. (2017)
Sponge bath/skin care	Often 2.2 Never 53.4	Zúñiga et al. (2015b)
Sponge bath/partial sponge bath/skin care	Often 5.9 Never 40.9	Norman and Sjetne (2019)
Sponge bath/partial sponge bath/skin care	Often 0.4 Never 77.8	Zúñiga et al. (2016)
Skin care	Leaving undone 10.0	Nelson and Flynn (2015)
Skin care	Leaving undone c. 16	White et al. (2019)
Care activities missed: Bathing	Yes 12.8	Knopp-Sihota et al. (2015)
Missed care: Bathing	Yes 7.1	Song et al. (2020)
Assistance with body cleaning		Tou et al. (2020)
Care activities missed: Hair care	Yes 13.8	Knopp-Sihota et al. (2015)
Care activities missed: Nail care	Yes 34.9	Knopp-Sihota et al. (2015)
Routine cutting of nails and facial hair		Tou et al. (2020)
Reminding of or assistance with hand cleaning		Tou et al. (2020)
Assessing and monitoring resident for healthy skin		Blackman et al. (2020)
Assessing residents for healthy skin		Henderson et al. (2018), Henderson et al. (2017)
Assisting with residents´ general hygiene (dressing/washing/grooming)		Blackman et al. (2020)
Assisting with residents´ hygiene		Henderson et al. (2017, 2018)
Assistance grooming after getting out of bed		Tou et al. (2020)
Oral or dental hygiene	Often 2.2 Never 55.4	Dhaini et al. (2017)
Oral or dental hygiene	Often 2.1 Never 54.1	Zúñiga et al. (2015b)
Assisting with residents´ mouth care		Henderson et al. (2017, 2018)
Care activities missed: Mouth care	Yes 19.3	Knopp-Sihota et al. (2015)
Missed care: Performing mouth care	Yes 14.1	Song et al. (2020)
Oral hygiene	Leaving undone 12.6	Nelson and Flynn (2015)
Oral hygiene	Often 8.1 Never 32.4	Norman and Sjetne (2019)
Oral hygiene	Often 1.8 Never 57.4	Zúñiga et al. (2016)
Oral hygiene/mouth care	Leaving undone c. 22	White et al. (2019)
Providing residents´ oral hygiene/teeth/mouth care		Blackman et al. (2020)
Assistance with oral care		Tou et al. (2020)
Care activities missed: Dressing		Knopp-Sihota et al. (2015)
Missed care: Dressing residents	Yes 5.3	Song et al. (2020)
Immediate replacement of dirty clothes		Tou et al. (2020)
Nutrition		
Preparing residents for meal time		Blackman et al. (2020)
Preparing residents for meal time		Henderson et al. (2017, 2018)
Assistance eating	Often 0.9 Never 74.1	Dhaini et al. (2017)
Assistance eating	Often 1.0 Never 73.8	Zúñiga et al. (2015b)
Assist food intake	Often 1.0 Never 82.8	Zúñiga et al. (2016)
Assist food/drink intake	Often 5.6 Never 45.4	Norman and Sjetne (2019)
Assist drinking	Often 0.4 Never 82.3	Zúñiga et al. (2016)
Care activities missed: Feeding	Yes 19.3	Knopp-Sihota et al. (2015)
Missed care: Feeding	Yes 6.2	Song et al. (2020)

(Continues)

TABLE 5 (Continued)

ITEMS	VALUES[a]	REFERENCES
Provision of nutritious and warm food		Tou et al. (2020)
Provide food other than regular meals	Often 2.9 Never 54.4	Norman and Sjetne (2019)
Assistance setting up a dining environment		Tou et al. (2020)
Assistance drinking	Often 1.1 Never 77.0	Dhaini et al. (2017)
Assistance drinking	Often 1.2 Never 76.8	Zúñiga et al. (2015b)
Assisting toileting needs		
Leaving a resident in urine and/or stool longer than 30 min	Often 0.9 Never 68.2	Dhaini et al., (2017)
Leaving a patient in urine/stool longer than 30 min	Often 3.1 Never 55.1	Norman and Sjetne (2019)
Leaving a resident in urine and/or stool longer than 30 min	Often 0.8 Never 68.0	Zúñiga et al. (2015b)
Leaving a resident in urine and/or stool longer than 30 min	Often 0.6 Never 79.0	Zúñiga et al. (2016)
Assistance using the bathroom or changing diapers within 5 min of a request		Tou et al. (2020)
Assisting residents´ toileting needs within 5 min of request		Blackman et al. (2020)
Assisting residents´ toileting needs within 5 min of request		Henderson et al. (2017, 2018)
Assist to the toilet when needed	Often 3.7 Never 39.1	Norman and Sjetne (2019)
Toileting and continence training	Often 2.6 Never 46.2	Dhaini et al. (2017)
Toileting and continence training	Often 2.7 Never 45.8	Zúñiga et al. (2015b)
Toileting and continence training	Often 2.3 Never 49.6	Zúñiga et al. (2016)
Care activities missed: Toileting		Knopp-Sihota et al. (2015)
Missed care: Toileting	Yes 9.5	Song et al. (2020)
Sleeping		
Care activities missed: Preparing residents for sleep		Knopp-Sihota et al. (2015)
Missed care: Preparing residents for sleep	Yes 7.3	Song et al. (2020)
Mobilization, rehabilitation, social/cultural activity		
Mobilization/changing position	Often 1.0 Never 69.1	Dhaini et al. (2017)
Mobilization/change of the position	Often 6.2 Never 41.9	Norman and Sjetne (2019)
Mobilization/change of the position	Often 0.4 Never 71.6	Zúñiga et al. (2016)
Mobilization/changing position	Often 1.0 Never 68.4	Zúñiga et al. (2015b)
Performing measures to reduce skin damage		Tou et al. (2020)
Moving residents confined to bed/chair pressure area care		Blackman et al. (2019)
Moving residents confined to bed or chair who cannot walk		Henderson et al. (2017, 2018)
Assistance turning over in bed every 2 hr		Tou et al. (2020)
Assistance getting out of bed		Tou et al. (2020)
Assisting residents with mobility (e.g. one-person transfers)		Blackman et al. (2020)
Assisting residents´ with mobility		Henderson et al. (2017, 2018)
Assistance sitting in a chair or wheelchair		Tou et al. (2020)
Ambulation/range of motion	Leaving undone c. 26	White et al. (2019)
Activation or rehabilitation care	Often 5.9 Never 37.5	Zúñiga et al. (2016)
Activation or rehabilitation activities	Often 6.6 Never 34.2	Dhaini et al., (2017)
Activation or rehabilitation activities	Often 6.3 Never 34.1	Zúñiga et al., (2015b)
Assistance with rehabilitation activities		Tou et al. (2020)
Prevention of falls		Tou et al. (2020)
Care activities missed: Taking residents for a walk		Knopp-Sihota et al. (2015)
Missed care: Taking residents for a walk	Yes 37.2	Song et al. (2020)
Supporting residents in their interests		Blackman et al. (2020)

(Continues)

TABLE 5 (Continued)

ITEMS	VALUES[a]	REFERENCES
Supporting residents to maintain their interests		Henderson et al. (2017, 2018)
Allow necessary time for patients to perform care themselves when possible	Often 15.8 Never 10.1	Norman and Sjetne (2019)
Providing residents activities to improve their mental and/or physical functioning		Blackman et al. (2020)
Providing residents with activities to improve their mental and physical functioning		Henderson et al. (2017, 2018)
Encouraging residents´ social engagement		Blackman et al. (2020)
Encouraging residents´ social engagement		Henderson et al. (2017, 2018)
Activity that she/he wanted	Often 32.3 Never 9.3	Norman and Sjetne (2019)
Scheduled single activity with a resident	Often 11.9 Never 24.9	Zúñiga et al. (2015b)
Scheduled single activity with a resident	Often 11.8 Never 26.4	Zúñiga et al. (2016)
Scheduled group activity with several residents	Often 7.5 Never 33.8	Zúñiga et al., (2015b)
Scheduled group activity with several residents	Often 6.9 Never 35.6	Zúñiga et al., (2016)
Assistance with group activities		Tou et al. (2020)
Experiencing community and meaning	Often 17.0 Never 13.9	Norman and Sjetne (2019)
Cultural activity for residents with contact outside of nursing home	Often 8.5 Never 32.4	Zúñiga et al. (2015b)
Cultural activity for residents with contact outside of nursing home	Often 7.6 Never 34.2	Zúñiga et al. (2016)
Communication, emotional support, counselling		
Emotional support	Often 5.2 Never 40.8	Dhaini et al. (2017)
Emotional support	Often 17.7 Never 22.7	Norman and Sjetne (2019)
Emotional support	Often 5.0 Never 40.8	Zúñiga et al. (2015b)
Emotional support	Often 4.8 Never 43.1	Zúñiga et al. (2016)
Comforting of patients	Leaving undone 33.5	Nelson and Flynn (2015)
Comfort/talking with patients	Leaving undone 50	White et al. (2019)
Providing emotional support to resident and/or family and friends		Blackman et al. (2020)
Providing emotional support for residents´ and/or family and friends		Henderson et al. (2017, 2018)
Emotional support for residents and family members		Tou et al. (2020)
Necessary conversations with residents and families	Often 6.6 Never 34.2	Dhaini et al. (2017)
Necessary conversation with patient and family	Often 7.7 Never 31.8	Norman and Sjetne (2019)
Necessary conversations with residents and families	Often 3.7 Never 45.1	Zúñiga et al. (2015b)
Necessary conversations with residents and families	Often 2.9 Never 49.0	Zúñiga et al., (2016)
Care activities missed: Talking with a resident		Knopp-Sihota et al. (2015)
Missed care: Talking with residents	Yes 32.7	Song et al. (2020)
Identifying the residents´ underlying mood or emotional state		Blackman et al. (2020)
Identifying residents´ underlying moods or social states		Henderson et al. (2017, 2018)
Interacting with resident when he/she has problems communicating		Blackman et al. (2020)
Interacting with residents´ when they have problems with communication		Henderson et al. (2017, 2018)
Teaching patients and families	Leaving undone 19.1	Nelson and Flynn (2015)
Teaching/counselling patients and families	Leaving undone c. 28	White et al. (2019)
Health promotion older people	Missed 73.5	Phelan et al. (2018)
Participation, dignity		
Fostering residents´ participation in decision-making		Blackman et al. (2020)
Encouraging residents´ participation in decisions about their care		Henderson et al. (2017, 2018)
Maximising residents´ dignity		Blackman et al. (2020)

(Continues)

TABLE 5 (Continued)

ITEMS	VALUES[a]	REFERENCES
Maximising residents´ dignity		Henderson et al. (2017, 2018)
Providing end-of-life care in line with residents´ documented wishes		Blackman et al. (2020)
Providing end-of-life care in line with residents´ wishes		Henderson et al. (2017, 2018)
Monitoring, surveillance		
Observation of signs of disease every shift		Tou et al. (2020)
Focused observations of signs of anomalies		Tou et al. (2020)
Monitoring of residents as necessary	Often 3.7 Never 46.4	Dhaini et al., (2017)
Monitoring patients as care workers felt necessary	Often 13.3 Never 24.7	Norman and Sjetne (2019)
Monitoring residents as care workers felt necessary	Often 3.3 Never 55.4	Zúñiga et al., (2016)
Monitoring of residents as necessary	Often 3.9 Never 45.7	Zúñiga et al., (2015b)
Patient surveillance	Leaving undone 15.0	Nelson and Flynn (2015)
Adequate patient surveillance	Leaving undone c. 28	White et al. (2019)
Taking vital signs/observations as required		Blackman et al. (2020)
Assessment of vital signs		Tou et al. (2020)
Monitoring of confuse/cognitively impaired residents & use of restraints/sedatives	Often 10.0 Never 30.8	Norman and Sjetne (2019)
Monitoring of cognitively impaired residents, including the application of restraints and sedatives	Often 3.9 Never 46.5	Dhaini et al. (2017)
Monitoring of cognitively impaired residents, including the application of restraints and sedatives	Often 4.0 Never 45.6	Zúñiga et al., (2015b)
Monitoring of confuse/cognitively impaired residents, and use of restraints and sedatives	Often 3.6 Never 49.6	Zúñiga et al., (2016)
Ensuring residents´ safety		Blackman et al. (2020)
Making sure residents are safe		Henderson et al. (2017, 2018)
Ensuring residents are not left alone when supervision is required		Blackman et al. (2020)
Ensuring residents are not left alone when supervision is required		Henderson et al. (2017, 2018)
Assessing and monitoring residents´ food/fluid intake		Blackman et al. (2020)
Monitoring residents´ food and fluid intake		Henderson et al. (;2017, 2018)
Recording of food intake and output		Tou et al. (2020)
Responding to call bells		
Keeping patients waiting who rung	Often 16.6 Never 16.1	Norman and Sjetne (2019)
Keeping patients waiting who rung	Often 7.5 Never 28.1	Zúñiga et al. (2016)
Keeping residents waiting following call bells	Often 9.2 Never 24.9	Dhaini et al., (2017)
Keeping residents waiting following call bells	Often 9.1 Never 24.4	Zúñiga et al. (2015b)
Responding to call bell/call alerts initiated within 5 min		Blackman et al. (2020)
Responding to call bells within 5 min		Henderson et al. (2017, 2018)
Responding to calls within 5 min		Tou et al. (2020)
Pain management, administration of medication on time		
Pain management	Leaving undone 1.8	Nelson and Flynn (2015)
Pain management	Leaving undone c. 4	White et al. (2019)
Assessing and monitoring residents for presence of pain		Blackman et al. (2020)
Assessing and monitoring residents for the presence of pain		Henderson et al. (2017, 2018)
Ensuring PRN medication acts within 15 min		Henderson et al. (2017, 2018)
Assistance with medications on time		Tou et al. (2020)
Giving prescribed medications within 30 min		Blackman et al. (2020)
Giving medications within 30 min of scheduled time		Henderson et al. (2017, 2018)

(Continues)

TABLE 5 (Continued)

ITEMS	VALUES[a]	REFERENCES
Ensuring PRN medication request are given promptly		Blackman et al. (2020)
Administer prescribed medication	Often 3.4 Never 36.6	Norman and Sjetne (2019)
Administration of medications on time	Leaving undone 7.1	Nelson and Flynn (2015)
On-time medication administration	Leaving undone c. 18	White et al. (2019)
Evaluating residents´ responses to medication		Henderson et al. (2017, 2018)
Ordered treatments and procedures, prevention		
Ordered treatments and procedures	Leaving undone 7.6	Nelson and Flynn (2015)
Treatment/procedures	Leaving undone 20	White et al. (2019)
Providing wound care (includes chronic wounds such as varicose, pressure ulcers and diabetic foot ulcers)		Blackman et al. (2020)
Providing wound care		Henderson et al. (;2017, 2018)
Change/apply wound dressings	Often 1.7 Never 40.8	Norman and Sjetne (2019)
Providing urinary catheter care		Blackman et al. (2020)
Providing catheter care		Henderson et al. (2017, 2018)
Taking vital signs as ordered		Henderson et al. (2017, 2018)
Maintaining monitoring residents´ blood sugar levels		Blackman et al. (2020)
Measuring and monitoring residents´ blood glucose levels		Henderson et al. (2017, 2018)
Maintaining IV or subcutaneous sites		Henderson et al. (2017, 2018)
Providing stoma care		Blackman et al. (2020)
Providing stoma care		Henderson et al. (2017, 2018)
Maintaining enteric tubes		Blackman et al. (2020)
Maintaining parenteral devices		Blackman et al. (2020)
Maintaining nasogastric or PEG tubes		Henderson et al. (2017, 2018)
Suctioning tracheostomy care		Blackman et al. (2020)
Suctioning airways/tracheostomy care		Henderson et al. (;2017, 2018)
Follow-up	Missed 62.6	Phelan et al. (2018)
Screening	Missed 58.6	Phelan et al. (2018)
Follow-up dementia	Missed 57.1	Phelan et al. (2018)
Prevention of infections		Tou et al. (2020)
Studying care plans, documentation, care planning		
Studying care plans at the beginning of shift	Often 26.1 Never 13.1	Norman and Sjetne (2019)
Studying care plans at the beginning of shift	Often 3.4 Never 31.9	Zúñiga et al. (2015b)
Studying care plans at the beginning of shift	Often 9.9 Never 45.9	Zúñiga et al. (2016)
Resident re-assessment to see if care requirements need to be changed		Blackman et al. (2020)
Reassessing residents to see if their care needs have changed		Henderson et al. (2017, 2018)
Developing or updating nursing care plans	Leaving undone 26.2	Nelson and Flynn (2015)
Developing/updating care plans	Leaving undone c. 28	White et al. (2019)
Set up or update patients´ care plans	Often 24.0 Never 9.6	Norman and Sjetne (2019)
Set up or update residents´ care plans	Often 9.8 Never 28.0	Zúñiga et al. (2015b)
Set up or update residents´ care plans	Often 4.8 Never 44.7	Zúñiga et al., (2016)
Completion of daily records		Tou et al. (2020)
Full documentation of all care including assessments and/or tasks		Blackman et al. (2019)
Full documentations of all care		Henderson et al. (;2017, 2018)
Documentation	Leaving undone 17.4	Nelson and Flynn (2015)

(Continues)

TABLE 5 (Continued)

ITEMS	VALUES[a]	REFERENCES
Adequate documentation	Leaving undone c. 25	White et al. (2019)
Documentation of care	Often 11.9 Never 22.0	Norman and Sjetne (2019)
Documentation of care	Often 7.3 Never 31.4	Zúñiga et al. (2015b)
Documentation of care	Often 7.1 Never 38.4	Zúñiga et al., (2016)
Maintaining "at risk register"	Missed 70.7	Phelan et al. (2018)
Coordinate patient care	Leaving undone 7.9	Nelson and Flynn (2015)
Care coordination	Leaving undone c. 11	White et al. (2019)
Participating in team discussions	Leaving undone c. 25	White et al. (2019)
Participating in interdisciplinary meetings		Tou et al. (2020)
Preparing patients for discharge	Leaving undone 4.7	Nelson and Flynn (2015)
Preparing patients and families for discharge	Leaving undone 10	White et al. (2019)
Intervening bad behaviour		
Intervening when residents´ behaviour is inappropriate or unwelcome		Blackman et al. (2020)
Intervening when residents´ behaviour is inappropriate or unwelcome		Henderson et al. (2017, 2018)
Mediating when residents say inappropriate or unwelcome things		Blackman et al. (2020)
Intervening when residents say inappropriate or unwelcome things		Henderson et al. (2017, 2018)
Intervening when residents are physically agitated		Blackman et al. (2020)
Intervening when residents are physically agitated		Henderson et al. (2017, 2018)
Own hygiene		
Ensuring nurses´/carers´ own hand hygiene		Blackman et al. (2020)
Ensuring own hand hygiene		Henderson et al. (2017, 2018)
General		
Due to the lack of time, I had to leave necessary care undone	Left undone 32.6 Not left undone 46.0	Senek et al. (2020)
Due to lack of time or resources, I had frequently been unable to complete necessary care.	Leaving undone c. 20	White et al. (2019)
How often does it happen that the allocated time isn´t sufficient to meet the needs of the client?		Hogh et al. (2018)
How often do you have to finish a visit with a client with the feeling that you have not done what was necessary?		Hogh et al. (2018)

[a]Empty boxes, in column values, represent no reported values in the paper.

modification increases the possibilities to capture that (Vincelette et al., 2019). There is a big difference in terms of number of items between studies, ranging from only one item (Senek et al., 2020) to studies with 44 items (Phelan et al., 2018), and more items usually ensure a greater reliability (Streiner et al., 2015).

There is also a difference in the starting points for the questions in the instruments. Some ask the informant to look back on their last seven work shifts (Dhaini et al., 2017; Norman & Sjetne, 2019; Phelan et al., 2018; Tou et al., 2020; Zúñiga et al., 2015a, 2015b, 2016), while others have them to look only at their most recent work shift (Knopp-Sihota et al., 2015; Nelson & Flynn, 2015; Senek et al., 2020; Song et al., 2020; White et al., 2019). This means that some informants must remember more shifts and more days back than others were told to. The starting point for answering the questions also varies between instruments, from missed nursing care being caused by lack of time and/or high workload (Dhaini et al., 2017; Hogh et al., 2018; Knopp-Sihota et al., 2015; Nelson & Flynn, 2015; Norman & Sjetne, 2019; Senek et al., 2020; Song et al., 2020; White et al., 2019; Zúñiga et al., 2015a, 2015b, 2016), to the questions being answered unconditionally of reason (Blackman et al., 2019; Henderson et al., ,2017, 2018; Phelan et al., 2018). The reported missed nursing care differs in terms of which tasks are most commonly missed, as showed in Figure 2, it is difficult to make an unambiguous interpretation from these findings since questionnaires, content of the items and starting points differ between the studies. However, missed nursing care is an existing problem and more research on the subject is needed.

All included papers, except one, are based on instruments in which the staff self-reported missed nursing care. This means that

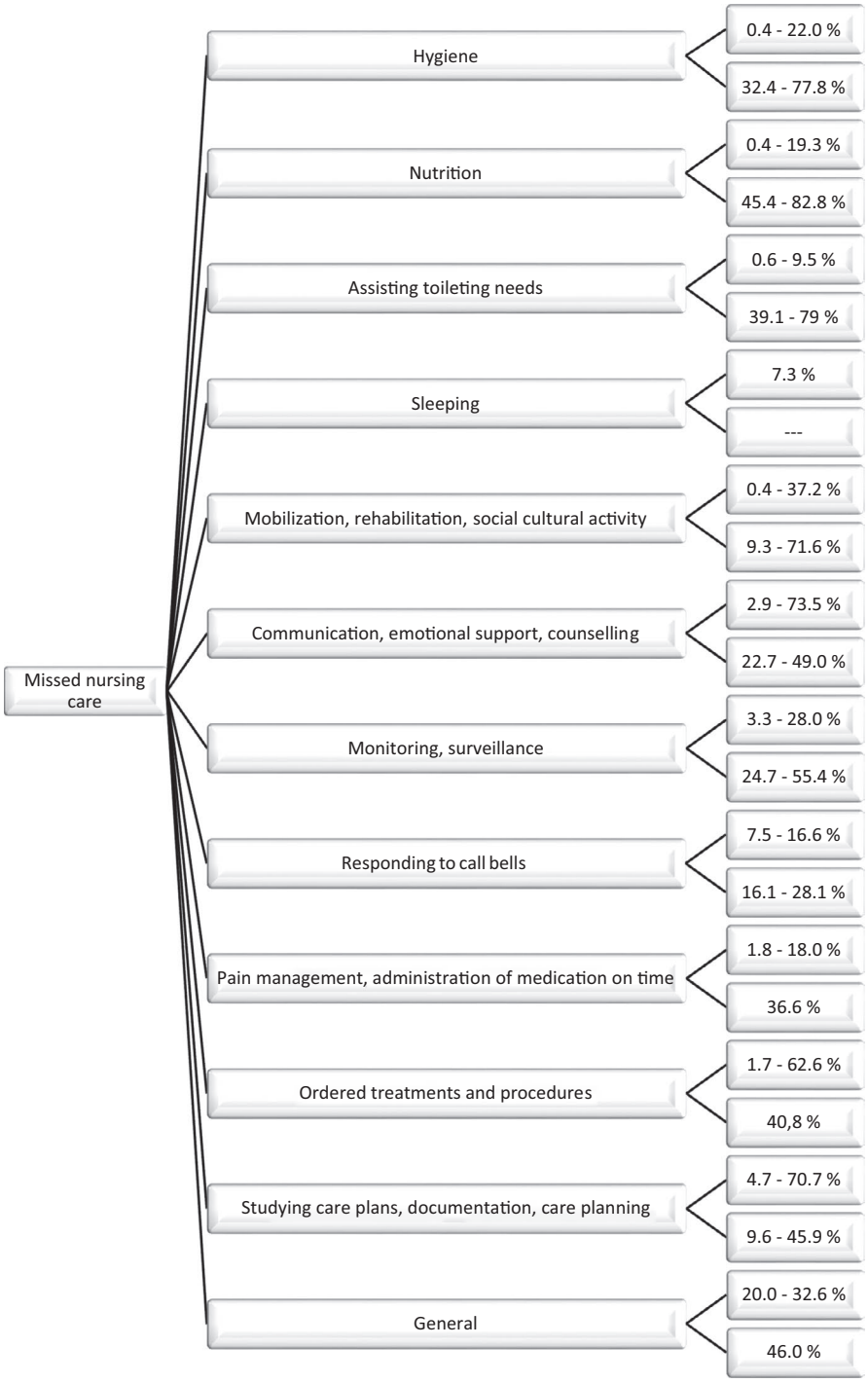

FIGURE 2 Missed nursing care, grouped and with lowest to highest values for reported missed nursing care (single values where only one value is available); the top box shows values for reported missed nursing care often occurring, and the bottom box shows values for reported missed nursing care never occurring

the informant himself or herself needs to be aware of tasks that should be done, otherwise he or she cannot be aware of what has been missed. There may also be a risk that some informants perceive the questions as a matter of conscience, to admit tasks that they are required to do, but have not done, even if the questionnaire is filled out anonymously. Self-reported instruments are vulnerable to this kind of bias (Vincelette et al., 2019).

The findings showed relations between missed nursing care and organization, working climate and impacts on the elderly. The findings about organization showed that one reason for missed nursing care was lack of staff or incorrect use of staff. In hospitals, low staffing is associated with missed nursing care (Griffiths et al., 2018), and this also occurs in the elderly care (Hegney et al., 2019). Lack of staff or incorrect profession is also seen as risk factors for unsafe health care (Andersson & Hjelm, 2017). Lack of time affects the ability to provide care and is seen as an organizational factor (Conroy, 2018). Depending on the profession, tasks were prioritized differently (Ludlow et al., 2020), so the staff's composition of different professions and its contribution to missed nursing care need to be further examined (Andersson et al., 2015). The structure of the organization is crucial when nurses prioritize their tasks (Tønnessen et al., 2011), as is the nurses´ ability to make decisions

TABLE 6 Cronbach´s alpha and ways of validation of the included instruments, where it is reported in included papers

Instrument	References	Cronbach´s alpha	Way of validation
Basel Extent of Rationing of Nursing Care for Nursing Homes; BERNCA-NH	Dhaini et al. (2017)	0.78–0.83[a]	Expert content validity testing Scale content validity index–averaging calculation method
BERNCA-NH	Zúñiga et al. (2015a)	0.77–0.86	Akaike Information Criterion
BERNCA-NH	Zúñiga et al. (2015b)	0.76–0.94	Akaike Information Criterion Exploratory factor analysis Confirmatory factor analysis
BERNCA-NH	Zúñiga et al. (2016)	0.77–0.89	Expert content validity testing Scale content validity index—averaging calculation method The within-group agreement Values variances between the individual ratings (Intra-class-correlation) Exploratory factor analysis Confirmatory factor analysis
Adapted & modified BERNCA-NH	Norman and Sjetne (2019)	0.933	Exploratory factor analysisConfirmatory factor analysis
MISSCARE framework	Blackman et al. (2020)	-	Rasch Analysis
Modified MISSCARE	Henderson et al. (2018)	-	-
Modified MISSCARE	Henderson et al. (2017)	-	Refer to other study
Modified MISSCARE	Tou et al. (2020)	0.96, 0.96, 0.97[b]	-
Inspired by MISSCARE	Phelan et al. (2018)	0.7–1.0	Exploratory factor analysis
Study-specific	Knopp-Sihota et al. (2015)	-	-
Study-specific	Song et al. (2020)	-	-
Study-specific	White et al. (2019)	-	-
Study-specific	Nelson and Flynn (2015)	-	-
Study-specific	Hogh et al. (2018)	-	-
Study-specific	Senek et al. (2020)	-	-
	Total	8	8

[a]Values reported with reference to earlier paper

[b]Values for Chinese, Indonesian and Vietnamese versions, respectively

which affect what care that will be done and what will be omitted (Cordeiro et al., 2020). There is a lack of research that examines the nurses´ process of decision-making when it comes to lack of time (Jones et al., 2020), a situation nurses should be prepared for (Jones et al., 2015).

5.1 | Strengths and limitations

To ensure the identification of relevant studies, all papers found in the search process were screened and later on read by at least two authors. However, there is a limitation in that only papers written in English are included, so relevant papers may have been missed. The lack of consensus for the concepts missed nursing care and community health care in research can lead to missed papers in the search process. To avoid that, multiple synonymous concepts for missed nursing care were used as the only search word. No grey literature was included in the study, and doing the quality appraisals is one way to ensure that the study is based on qualitative research (Arksey & O'Malley, 2005; Munn et al., 2018). Quality appraisals are not regarded as required in scoping reviews (Arksey & O'Malley, 2005), but recommended by Daudt et al. (2013). Grant and Booth (2009) mean that no qualitative appraisal is a shortcoming. To overcome this limitation, the current study included a quality appraisal of identified and included papers. As a result, the parts with qualitative design, included in the two studies with

both a quantitative and qualitative design, were excluded. There is a lack of studies that have used designs other than cross-sectional (Vincelette et al., 2019), which would give more knowledge about the phenomena (Mandal et al., 2020). A scoping review is a way of mapping existing research in an area to find out gaps in the research field (Arksey & O'Malley, 2005; Munn et al., 2018). It is not looking to synthesize results from the papers: instead it can be seen as a step towards what questions are relevant for a systematic review (Arksey & O'Malley, 2005). There are still few studies in the area; however, an increasing interest of research and publication of papers will make it possible to see evidence and/or directions important for the state of knowledge.

5.2 | Conclusion

This review shows that missed nursing care exists in community health care and is affected by factors from both organization and working climate. Missed nursing care is a field of importance for staff, patients and leaders given its relation to patient safety and quality of care, it becomes even more important and should be put on the agenda and secured as a relevant subject. It is important that nurses and other healthcare staff know that missed nursing care exists and that there is a possibility to measure it, which gives them an opportunity to act for a change. Earlier studies have shown that missed nursing care affects both quality of care and patient safety, so it is vital that these factors are taken into account in managers´ decision-making. This could increase the quality of care and safety for elderly people in need of health care in community contexts. This review also contributes with a comprehensive compilation of the concept missed nursing care of elderly and could serve as a basis for instrument development. Future research is needed to further examine the meaning and content of missed nursing care in different national contexts, from different groups of staff perspectives, and within different organizations. It would also be of interest to examine opinions about the consequences and causes of missed nursing care from staffs´, managers´ and elderlies´ perspective.

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CONFLICT OF INTERESTS

The authors declare no conflicts of interest.

ETHICAL APPROVAL

In a scoping review, Research Ethics Committee approval is not required.

DATA AVAILABILITY STATEMENT

The authors confirm that the data supporting the findings of this study are available within the article.

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