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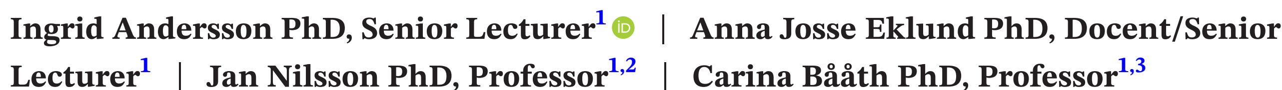
First-line managers´ perceptions of missed nursing care in community health care for older people–A phenomenographic study



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Abstract

Introduction: First-line managers in Swedish communities have responsibility for that care to older people is provided, staffing is sufficient and the budget is balanced in their unit. It is a struggle with limited resources due to a growing population in need of care. This can lead to missed nursing care. The aim was to describe first-line managers´ perceptions of missed nursing care in community health care for older people.

Methods: A qualitative design with a phenomenographic approach, interviewing 24 first-line managers. Ethics approval for the study was received from the Research Ethics Committee at Karlstad University (Dnr HNT 2020/566).

Results: The results are shown in six descriptive categories containing 15 perceptions. The descriptive categories are 'occurrence of missed nursing care', 'becoming aware of missed nursing care', 'reasons for missed nursing care', 'missed nursing care has consequences for the older persons', 'missed nursing care has consequences for the staff' and 'taking action to decrease missed nursing care'.

Conclusions: It is important for first-line managers to become aware of the existence and reasons for missed nursing, as it has consequences for older people and staff. Managers need to take missed nursing care seriously in order to work with improvements for maintaining good quality of care and patient safety.

KEYWORDS

ageing, community nursing, management, missed nursing care, older people, phenomenography

INTRODUCTION

Today, people around the world are living longer. The health care system faces a challenge to meet the needs of an ageing population and to facilitate healthy ageing [1]. In addition, there is also a challenge to provide enough staff and the right competencies [2]. When health care staff lacks education and competence, adverse events occur, sometimes caused by missed nursing care [3]. Missed nursing care as a concept and phenomenon includes all care that is omitted or delayed [4]. Different concepts are used synonymously, where the definition is similar [5] or

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the same [6]. A study of missed nursing care in community health care showed that the care activity that staff most often missed in nursing homes was scheduled group activities and in home care it was updating care plans. Reasons for missed nursing care were deficient preparedness for unexpected situations, obstacles in a lacking work environment, insufficient planning and shortcomings related to the staff [7]. Renner et al. [8] saw an increase of missed nursing care in the last 5 years, at the same time, there had been an increased shortage of staff, as well as the right competencies. The study's conclusion is that both decision-makers and managers face a challenge in ensuring a high quality of care, where there are sufficient staff resources with the right skills and missed nursing care is not increasing [8]. Missed nursing care needs to be taken seriously, since it can jeopardise both quality of care as well as financial conditions. The leadership needs to be aware of the existence of missed nursing care and consider what policy and practice reforms are required to decrease the incidence of missed nursing care [9].

Swedish community health care is regulated by two laws: (1) the Health and Medical Services Act ([10]:30) and (2) the Social Services Act ([11]:453), which states obligations to offer health care services and support to older people in their homes or in nursing homes. Enrolled nurses or nurse assistants usually provide the care, but a Registered Nurse is responsible for all fundamental care and treatments. The Registered Nurse often delegates tasks, e.g. drug administration, and wound care, to the enrolled nurses and assistant nurses [12], otherwise the organisation would not work due to a lack of Registered Nurses [13]. Persons receiving care and support at home or in nursing homes pay a fee that is to some extent subsidised by taxes. In Sweden, there is a constitutional community health care organisation with managers at various levels. The highest responsible and top decision-making body in community health care is a political committee. Each municipality creates its own organisation where the numbers of managerial levels differ. A non-political Executive Operations Manager is in charge of the operative part of health care and it is common practice to have a manager at each nursing home and home care unit. Registered Nurses, even if they work in nursing homes and home care, often make up a separate unit with one manager. These managers are the lowest-ranking managers in the health care organisation and often referred to as first-line managers.

Health care organisation in communities in the Nordic countries has been influenced by New Public Management and reformed accordingly. The first-line managers are not always as Registered Nurses, as they used to be and their responsibility for finances has increased [14]. The first-line managers have to provide timely and safe care for the older and have a budget in order. Some first-line managers claim that they have chosen a position where they still are close to the older people and clinical work, even if they sometimes feel powerless in their position [15].

To have a successful leadership in community health care for older people, managers must have a clear vision that can be communicated to the older people, their families and the staff. To accomplish this, managers need a mixed skill set, such as the ability to communicate with empathy and kindness, together with caring, compassionate and person-centred leadership [16]. Staff that works in direct care need supportive leadership, otherwise they feel invisible, which will have a negative impact on care [9]. Missed nursing care exists in the community health care, where first-line managers are responsible for that older people are given safe care of high quality, a need that is increasing. Therefore, the aim of this study was to describe first-line managers´ perceptions of missed nursing care in community health care for older people.

MATERIALS AND METHODS

A qualitative design with a phenomenographic approach was used. Phenomenography describes a phenomenon in the world based on the existing variations from the eye of the beholder [17, 18], which describes people's conceptions of the world–also known as the second-order perspective. The first-order perspective means describing the world itself [17, 19]. Variations of the perceived phenomenon provide a whole in the outcome space, based on the pattern of similarities and differences that comprises the descriptive categories. The categories are separate and describe different aspects of the phenomenon and their relationships [18]. The study used the consolidated criteria for reporting qualitative research (COREQ) [20].

Setting and sample

Executive Operations Managers in health care for older people in four Swedish communities were contacted for permission to conduct the study. Then, information and an enquiry of participation were sent to the first-line managers. It was a purposeful sampling in order to interview both women and men as first-line managers in nursing homes, home care and for Registered Nurses. All first-line managers were given both written and oral information. Interviews were conducted with 24 managers from four small to middle-sized communities in Sweden. The participants age varied between 31 years and 65 years (MD = 51–55 year). They had been first-line managers of their current unit for between 3 weeks and 16 years,

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(MD = 2 years), please see Table 1 for demographic information.

Data collection

The data was collected from January to April 2022. The first-line managers were individually interviewed by the first author via Zoom. The participants were interviewed during their working hours, at a location chosen by them, sitting in their offices or at their workplace from home due to the COVID-19 pandemic. The interviews were semi-structured and started with an open-ended question regarding the first-line managers´ perceptions of missed nursing care in their unit. Follow-up questions were asked in order to make them further explain the phenomenon of missed nursing care. The interviews lasted between 14 and 35 minutes (M = 23 min) and were recorded and transcribed verbatim.

TABLE 1 Participants´ demographics (n = 24).

	n
Gender	
Female	19
Male	5
Age	
31–35 year	2
36–40 year	4
41–45 year	2
46–50 year	3
51–55 year	3
56–60 year	7
61–65 year	3
Total number of years as a first-line manager	
≤1 year	3
>1–5 year	6
6–10 year	7
11–20 year	1
>21 year	7
Years as manager at current unit	
≤1 year	10
>1–5 year	8
6–10 year	4
11–16 year	2
Manager for	
Enrolled nurses and nurse assistants working in nursing homes	9
Enrolled nurses and nurse assistants working in home care units	10
Enrolled nurses and nurse assistants working in both nursing homes and home care units	2
Registered Nurses working in both nursing homes and home care units	3

Data analysis

To describe the variations of the participants´ perceptions of the phenomenon missed nursing care, the phenomenographic approach was used, according to Dahlgren and Fallsberg's [21] seven steps. The first step was to read the data thoroughly to be acquainted with the data, seen as a *familiarisation* with the material. In the second step, *condensation*, statements were found that clarified the participants' descriptions of the phenomenon. In the third step, a *comparison* started and variations or similarities were identified, which later on, in the fourth step made it possible *to group* similarities. In the fifth step, an *articulating* of the essence of the similarities started, which in the sixth step ended with *labelling* the categories. The seventh step included a comparison of the differences and similarities in the categories to ensure they were *contrasting* to each other. The analysis process went back-and-forth between the steps, in order to catch the essence of the perceived phenomenon. All qualitative analyses of examined phenomena include both description and interpretation and phenomenography implies more description than interpretation. Still the analysis was inductive and the defining of the categories was derived from the collected data [21].

Ethical considerations

Ethics approval for the study was received from the Research Ethics Committee at Karlstad University (Dnr HNT 2020/566). The Executive Operations Managers for Health Care in four Swedish communities gave permission for the study and for the authors to contact and interview first-line managers. All participants were given written and oral information about the aim of the study and that their participation was voluntary, with the right to withdraw whenever they wanted. Informed consent was provided before starting each interview. The collected data were treated confidentially. The researchers followed the ethical guidelines, in the Declaration of Helsinki concerning confidentiality integrity and voluntariness [22].

RESULTS

The first-line managers´ perceptions of missed nursing care in community health care for older people are shown

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in six descriptive categories containing 15 perceptions. The descriptive categories are 'occurrence of missed nursing care', 'becoming aware of missed nursing care', 'reasons for missed nursing care', 'missed nursing care has consequences for the older persons', 'missed nursing care has consequences for the staff' and 'taking action to decrease missed nursing care'. The presentations of the descriptive categories and their relationships are shown in Figure 1.

Occurrence of missed nursing care

The descriptive category 'occurrence of missed nursing care' contains three perceptions. The managers´ perceptions of missed nursing care varied depending on whether they at all perceived that the phenomenon existed at all or not. There were managers who expressed that a vision of no missed care was ideal, but unrealistic, which is why *missed nursing care exists*. 'In the best possible world, you don't want to know that it exists at all. But unfortunately we know that it does'. (Manager 8). Some managers claimed that *missed nursing care happens rarely* and it was so unusual that it was not worth talking about it. In those cases when it did happen, there was always an explanation, e.g. the older person had refused to receive help, had specific wishes when it came to which staff member should help them or that the older person was not at home. '...so in my world, nothing is left out. The only time something is not done, is when the client himself does not want to take a shower, for example, or does not want help with food or something'. (Manager 9). The managers said there was no tolerance for not performing all tasks, there is enough time and missing a task could be avoided through good planning and prioritisation. If all care is done, there is no need to prevent or in any other way talk about it, *it does not exist*. 'So I mean, that the older persons don't receive the right care, it's like I'm a little tired of, if I say, that... I don't think that happens'. (Manager 12).

Becoming aware of missed nursing care

The descriptive category 'becoming aware of missed nursing care' contains three perceptions. The managers perceived that they could never know for sure whether all missed nursing care came to their attention. Still managers thought that there probably were *unrecorded* instances of missed nursing care, care that should have been performed, but was not, and was not documented as missed.

> 'Somehow they still get it together and go home when the day is done. And if you check then, you can see that some visits have taken less time than they should and then of course you think about, whether all tasks have been performed or are there some things they didn't have time for, or did they work more quickly, or maybe this is the time to do the little extra or sit and talk for a while. Were they been able to reduce something, since they could to do everything in a less time. You don't always know that'.
>
> (Manager 15)

The managers described that one way to become *aware of missed nursing care was because someone informed* them about it. The managers trusted that a member of the staff would point this out or sometimes the older person or a family member got in touch and told the manager that care was undone. Some managers thought that having their office in the same building as

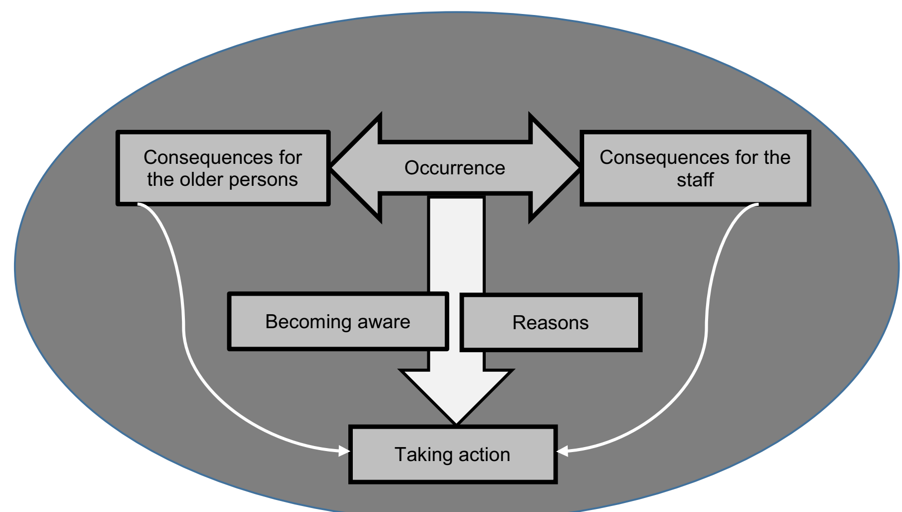

FIGURE 1 Overview of the relationships of the descriptive categories (abbreviated) showing the first-line managers' perceptions of missed nursing care.

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the staff, entailed good ways to catch up with what the staff talked about, which would make them prone to signal if problems arose.

> 'I sit with them, having my office nearby the registered nurses. I'm in every morning meeting, I see them at lunch, I see them… We're a team so I hear… I'm in the discussions, I'm there when we report, so I hear what's happening. …I'm very involved in the business'.
>
> (Manager 7)

Another way, expressed by the managers, to get *awareness is through controls of documentation and login*, to find out whether nursing care had been missed. The manager could read the documentation daily or more randomly. In home care there was also a possibility to see if and when a staff member logged in at a visit. 'I see exactly in the computer, that is, how long staff are with each client; I can see exactly how many gaps there are. I sort of see everything, everything is logged'. (Manager 9).

Reasons for missed nursing care

The descriptive category 'reasons for missed nursing care' contains three perceptions. The managers expressed that there is nearly always a reason for missed nursing care. Sometimes the care is scheduled away in advance and *it is a planned prioritisation*. This may be a result of external reasons such as lack of time or staff, a high workload, stressful environment or deficiencies in communication between staff. 'We plan to move tasks in that case. It is not that common that it happens without us having made a prioritisation order'. (Manager 11).

Managers perceived that sometimes care is *missed because of an unexpected situation*, which often leads to prioritisation of other tasks because there is no time scheduled for unexpected events such as standing and waiting for an ambulance or going on a call when an older person has pushed an alarm button.

> 'If two go on a call where someone has fallen, it could be that, that they might, yes it has happened sometimes that you might have missed a visit'.
>
> (Manager 21)

Managers stated that one reason for missed nursing care could be that *the care was disregarded deliberately or unintentionally*. This could happen due to personal characteristics such as uneducated or inexperienced staff, carelessness or a language barrier, but some managers said it is human to make mistakes and everyone sometimes forgets tasks.

> 'Because it can be… well, blood pressure medication that is missed or something likes this, so that… it happens. Not every month, but it definitely happens. Because we are human and people are careless and things go too fast and… and so on'.
>
> (Manager 5)

Missed nursing care has consequences for the older persons

The descriptive category 'missed nursing care has consequences for the older persons' contains two perceptions. Most of the managers perceived that missed nursing care had consequences for the older person even if some managers expressed that there were no consequences. These consequences of missed nursing care could *affect and cause physical illness*, including health risks, adverse events or mistreatment. '…a malnourished patient, well, what does that lead to? Yes, we know that, one, malnutrition leads to pressure ulcers, poor activity, risk of contractures, greater risk of falling'. (Manager 3). The consequences could also *affect and cause mental distress* with feelings of lost trust, insecurity, reduced wellbeing and lower quality of life.

> '…reduced quality of life, I think, compared to what it would have been if you had been able to get an activity every day or get that kind of needs met, that you should really have, which might have had to be put back. I think it is, it can both be a reduced quality of life but also that it doesn't feel as worthy'.
>
> (Manager 19)

Missed nursing care has consequences for the staff

The descriptive category 'missed nursing care has consequences for the staff' contains two perceptions. Managers expressed that there could be consequences for the staff, but some thought there were no consequences for the staff due to missed nursing care. These consequences could be *affecting issues concerning labour laws*, like formal warnings of misconduct, withdrawn delegations for medical interventions or termination of employment. '…someone who lost his delegation for half a year'. (Manager 17). Other consequences for the staff were also perceived as

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affecting and causing mental distress, with feelings of dissatisfaction and inadequacy, anxiety, frustration and bad conscience, which in the worst-case scenario could lead to a staff member ending up on sick leave.

> '…as a member of the staff you feel an inner stress of not being enough. Many times, you just bite the bullet and do this, even though you're completely exhausted and feel bad, because you don't want to… you want so badly to do good'.
>
> (Manager 4)

Taking action to decrease missed nursing care

The descriptive category 'taking action to decrease missed nursing care' contains two perceptions. The managers stated that they had an obligation to *investigate and follow up* on situations to find out why the care had not been carried out and how this could be avoided in the future. Managers had to analyse the situation and find out whether it was a task that often was missed and consider whether an adverse event report needed to be filed out and communicate this with staff or involving other team members with specialist knowledge to help find a solution. It could also involve informing the older person and his/her family of what had happened and why.

> '…to take ownership of the problems that exist… when they appear. And like analysing, why do they happen? How can we minimize them? What can we do so that they, in the best possible world, never happen again?'
>
> (Manager 5)

The managers also saw a possibility to learn from the situation and come up with strategies to *prevent* it from happening again. To see whether procedures needed to be updated, whether the organisation or working environment needed a better balance or whether there was a need for education and rethinking among staff members.

> '…we are constantly working on finding faults in the system, so to speak… No, but, now it has been very busy in the evening. We need to plan differently. Yes, but then we kind of do it. And it's also a way to, it mustn't be too much so that… so that they (staff) don't have the time or they forget, you need to have a constant dialogue to prevent this'.
>
> (Manager 6)

DISCUSSION

The main findings of the study show that first-line managers' perceptions of missed nursing in community health care for older people were defined in six descriptive categories. The categories were: 'occurrence of missed nursing care', 'becoming aware of missed nursing care', 'reasons for missed nursing care', 'missed nursing care has consequences for the older persons', 'missed nursing care has consequences for the staff' and 'taking action to decrease missed nursing care'.

Not all first-line managers in the present study expressed that missed nursing care existed in the unit. However, studies in community health care show that missed nursing care does exist [7, 23–36]. For at least 7 years, studies from community health care in different countries, such as Australia, Sweden, Denmark, Switzerland, Ireland, Canada and the US, have examined the existence of missed nursing care. It differs between countries what care is missed, but all studies show that it does happen. Overall, first-line managers have a responsibility to ensure that all work in the organisation is performed and in order to decrease missed nursing care, it first needs to be acknowledged.

The first-line managers need to become aware of missed nursing care, knowing that there are unrecorded cases. Staff members told the first-line managers when care was not performed, so first-line managers need to foster a permissive work climate where no one is afraid of speaking up when things go wrong. He et al. [37] stated that a negative working climate, where the staff does not feel safe, leads to a negative association between patient safety culture and barriers to report adverse events. The amount of missed nursing care depends on the working climate, where a more favourable organisation leads to less missed nursing care [33].

In the present study, the first-line managers perceived that they had a responsibility to ensure that all interventions and tasks were performed and they could see reasons for missed nursing care. External reasons for missed nursing care were a lack of staff and that staff had inadequate education. Insufficient staffing is an increasing problem in many countries [38], with a connection to missed nursing care [26, 39]. The occurrence of missed nursing care increased when there were fewer Registered Nurses than it was scheduled [32]. Care providers seem to underestimate that one contributing factor to adverse events is lacking competence in staff [3]. It is first-line managers′ responsibility to ensure sufficient staffing, with the right skills, which can be difficult as there is a shortage of educated nurses. At the same time, the older people in the community have an increasing need for care in home care and in nursing homes, both in number and in complexity. Even if the need for care is fairly constant in terms of age,

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the need for resources will increase as the proportion of older people in the population increases [40].

The first-line managers in the study gave examples of missed nursing care and all who mentioned planned prioritisation had social activities low in the priority chest. If you need to choose between medication, food or taking a walk, it may seem like an easy choice. However, all activities are assessed based on the older person's needs ([11]:453) and should be of equal importance. Van Aerschot et al. [41] study showed that older people often felt their psychosocial needs were unmet. The health care system for older people is task-oriented and prioritises activities related to daily living, such as nutrition and medication [41]. Not taking into account the consequences for the older person, and how, for example appetite or wellbeing could be affected of a lack of social activity. The first-line manager has a responsibility to ensure that the older person receives the care he or she needs, regarding both fundamental care and medical care. In Sweden, this is assessed and granted by someone else than the first-line manager. In addition, the interventions are assessed and granted in two different systems, governed by two different laws although performed in the same organisation, sometimes even by the same staff. First-line managers have personnel responsibilities for enrolled nurses and nurse assistants in nursing homes/homes care or for a unit of Registered Nurses. The older person's safety and granted interventions in nursing homes or at home become a shared responsibility where the Registered Nurse has responsibility for the medication, although it may be delegated to the enrolled nurses. This entails two different systems for documentation depending on the intervention. The responsibilities for first-line managers are complex. Solbakken et al. [14] findings show that first-line managers are responsible for all issues concerning care, advocating for the older person, building relationships with staff and making sure the budget is in balance. All of this with the purpose of delivering safe care of high quality.

Furthermore, the managers perceived consequences that affected the staff's wellbeing, when care was not performed. In the worst-case scenario, it could mean that staff members end up on sick leave. This is consistent with findings from staff reporting reasons for missed nursing care and how the nurses expressed feelings of fatigue and not being able to perform as well as they wanted, where also lack of time and resources were reasons for missed nursing care [7]. The first-line managers in health care have a challenge to overcome with finding enough resources with the right mix of skills, retention and recruitment of new staff members [42]. Population ageing makes staffing a challenge for health care organisations in many countries worldwide [1].

The managers expressed that they need to take action to decrease missed nursing care and one way to do this is to follow up and communicate with staff, both individually and in general staff meetings. Devik et al. [43] identified that managers expressed that having continuous appraisal individual meetings with staff was one way to get to know the qualities as well as the shortcomings.

Strengths and limitations

Phenomenography is a suitable method to catch variations of individual perceptions. In phenomenography, a phenomenon has limited ways of being perceived [18]. Indeed, the last interviews in this study presented no new aspects of the phenomenon, although it is possible that something more might come to light if more interviews had been performed. This study contributes to illuminate variations of first-line managers´ perceptions of missed nursing, but more studies are needed in this context. The generalisation of the findings can be assessed, in similar contexts as the variations of the phenomenon [18].

Trustworthiness can be illustrated by assessing transferability, credibility, dependability and confirmability [44]. The richness of quotations from the interviews has been made for increase the transferability. The first author performed all the interviews, but all authors have read the transcripts and contributed to the analyses and discussion of the descriptive categories, to strengthen credibility. The credibility and confirmability are also strengthened through the quotations in the result section. The same open-ended question was posed to all participants, which strengthens dependability.

CONCLUSIONS

First-line managers have a responsibility for everything that happens in the organisation at their unit including both staff and the older persons. It is important to be aware of that missed nursing care exists and the reasons for it, to be able to act. Knowing that missed nursing care has consequences for both older people and staff and some of these consequences may be serious for the persons involved. First-line managers who admit the existence of missed nursing care are able to work with improvements to ensure quality of care and patient safety.

More studies are needed to better understand why missed nursing care is missed and how health care staff prioritises what care to do or not. It is important to work systematically, with measurements, to put missed nursing care on the agenda for the first-line managers. It can be one way to map the existence of missed nursing care and if there is specific tasks that are missed, it can provide knowledge about the need for education and improvement work in order to ensure good quality of care and patient

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safety. First-line managers have a position where they are able to hear out the staff in direct care with the older people as well as put the issue of missed nursing care on the agenda for the Executive Operations Managers.

AUTHOR CONTRIBUTIONS

All the authors IA, AJE, JN and CB have participated in the design, planning and development of the study. IA has done the data collection. The analyses were a collaboration with all authors. IA was mainly responsible for drafting the manuscript and AJE, JN and CB contributed with critical revisions and important intellectual content. All authors read and approved the final manuscript.

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CONFLICT OF INTEREST STATEMENT

The authors declare that they have no competing interests.

DATA AVAILABILITY STATEMENT

The datasets used during the current study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

Ethics approval for the study was received from the Research Ethics Committee at Karlstad University (Dnr HNT 2020/566).

PATIENT CONSENT STATEMENT

Not applicable.

PERMISSION TO REPRODUCE MATERIAL FROM OTHER SOURCES

Not applicable.

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