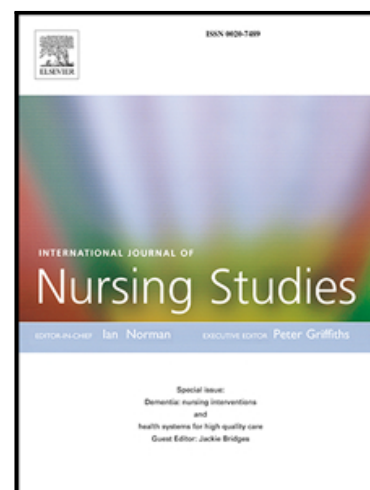


“It’s about how we do it, not if we do it”. Nurses’ experiences with implicit rationing of nursing care in acute care hospitals: a descriptive qualitative study

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“It’s about how we do it, not if we do it”. Nurses’ experiences with implicit rationing of nursing care in acute care hospitals: a descriptive qualitative study

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ABSTRACT

Background: The phenomenon of *unfinished nursing care* is gaining increasing interest among nursing researchers. While survey studies on the underlying concepts, e.g., implicit rationing of nursing care, revealed frequencies, antecedents and consequences, little is known about how nurses experience care rationing in clinical practice.

Objectives: The aim of this study was to explore nurses' experiences with implicit rationing of nursing care in acute-care hospitals.

Design: We conducted a qualitative study using interpretive description methodology.

Methods: Using a convenience sample of 31 frontline nurses (i.e., registered nurses, nurse assistants) and 19 ward nurse managers from acute care units in seven hospitals in [Blinded], eight semi-structured focus group interviews were conducted, transcribed verbatim and analyzed via thematic analysis.

Results: Our findings indicate three interconnected themes: a) maintaining stability within complexity; b) applying strategies to limit rationing; and c) nursing care between ideal and reality. According to study participants, implicit rationing of nursing care results when nurses cannot otherwise maintain stability for their patients and their units. Nurses reported several

strategies, including postponing tasks or reducing quality, to prevent or limit rationing.

Rationing accentuates the gap between ideal nursing care and day-to-day practice.

Conclusions: In absence of guidelines on implicit rationing of nursing care nurses rely on intuitive and situational processes of decision-making and priority setting. Technical activities addressing patients' instability receive higher priority than relational ones. As quality may be an earlier casualty of implicit rationing than quantity, it challenges us to broaden the current focus of how care rationing manifests. In addition to encouraging open discourse on implicit and non-transparent rationing at all organizational levels, this qualitative study provides new insights that will inform the development and implementation of interventions to support nurses' priority setting and ultimately to limit rationing of nursing care.

Keywords: Health Care Rationing, unfinished care, implicit rationing of nursing care, quality assurance, health care, hospital administration, nursing, qualitative research

CONTRIBUTION OF THE PAPER

What is already known about the topic:

- Nurses practice in complex and dynamic situations; when resources are inadequate, they *ration* necessary nursing care.
- *Implicit rationing of nursing care* and related concepts (e.g., *missed care* or *care left undone*) are attracting increasing interest from researchers worldwide.
- Little is known of how nurses working in acute-care hospitals experience and face implicit rationing of nursing care in daily clinical practice.

What this paper adds:

- Implicit rationing of nursing care is described as the process of intuitive, situational decision-making and priority setting.
- Before rationing or leaving care activities unfinished, nurses apply several strategies, including postponing activities and/or reducing their quality.
- As emerged from the interviews, implicit rationing of nursing care accentuates the gap between the ideal of nursing care and the reality.

1 BACKGROUND

Over the past decade, the phenomenon of *unfinished nursing care*, which includes *implicit rationing of nursing care*, *missed care* and *care left undone* (Jones et al., 2015), has been a subject of growing interest among nursing researchers around the world (Lauridsen et al., 2007, Papastavrou et al., 2014, [Blinded]). Although the theoretical assumptions, conceptual definitions and operationalizations differ substantially across the three concepts (Jones et al., 2015), nurses' self-reports on unfinished care have revealed common types, patterns and correlates ([Blinded], Kalisch et al., 2009). For example, among the activities most often rationed, missed or left undone by nurses are *talking with patient* (53% -66%) ([Blinded], Ball et al., 2014, Kalisch, 2006), *educating patients and families* (58%-80%) ([Blinded], Kalisch et al., 2009), and *developing or updating nursing care plans/care pathways* (42%-47%) ([Blinded], 2014, Ball et al., 2014).

Higher levels of unfinished care have been correlated negatively both with patient safety and quality of nursing care (Ball et al., 2018, Papastavrou et al., 2014), and positively with in-patient outcomes including medication errors, bloodstream infections, pneumonia, urinary tract infections, falls, pressure ulcers and 30-day mortality (Ball et al., 2018, Recio-Saucedo et al., 2018). Unable to offer what they consider an 'optimal' care, i.e., all necessary nursing care to all patients (Papastavrou et al., 2014, Vryonides et al., 2015) nurses feel guilty. This leads to positive connections with nurse job dissatisfaction, burnout and intention to leave (Banning, 2008, Kalisch et al., 2009, Shin et al., 2018). Nurses more often report leaving care unfinished in hospital work environments with lower nurse-to-patient ratios (Ball et al., 2014, Jones et al., 2015).

Nurses practice in highly dynamic situations; and when resource scarcities occur, they have no choice but to ration necessary care. Implicit rationing of nursing care has been defined as *the withholding of or failure to carry out all needed nursing interventions in the*

face of inadequate time, staffing or skill mix ([Blinded]). Considering that health care need is limitless and resources (e.g., health care personnel) are not, rationing of services is considered unavoidable (Oduncu, 2013). In creating a sustainable and just health-care system, the levels at which health care is rationed and the transparency of rationing are important structural considerations (Scheunemann and White, 2011). While *rationing* refers to reducing allocations of beneficial healthcare care (in terms of improving health status, or length and quality of life) intended for and/or desired by patients ([Blinded]), *implicit* rationing limits the range of choices available to patients (Lauridsen et al., 2007). It involves the distribution of scarce resources in absence of regulations, guidelines or explicit criteria, and is therefore often hidden from patients. Although implicit rationing of nursing care occurs, by definition, at the micro-level, i.e., at the nurse-to- patient interface, it usually results from macro- and meso-level policy or management decisions (e.g., cost containment strategies, budget reductions) (Harvey et al., 2018, Lauridsen et al., 2007).

At the micro-level, nurses seek to provide high-quality care to the patients who depend on them. Resource shortfalls lead them to the implicit rationing of that care, the details of which depend on their decisions and priorities (Suhonen et al., 2018). When this happens, nurses find themselves constantly deciding which activities are necessary for which patients (given their conditions) and whether alternatives are available (Thompson et al., 2004). Nurses' decision making is a multidimensional process (Banning, 2008), *a contextual, continuous, and evolving process, where data are gathered, interpreted, and evaluated in order to select an evidence-based choice of action* (Tiffen et al., 2014). For instance, among nursing care-related decision-making models described in the literature are the information-processing (analytical) and the intuitive-humanist model (Banning, 2008). In daily clinical practice, alongside making decisions, nurses have to set priorities, i.e.,

the classifying of problems and concerns into those that require immediate actions and responses and those that can be delayed until a later time, and the ranking of problems and concerns,

utilizing notions of urgency and/or importance in order to establish a preferential order for nursing actions(Hendry and Walker, 2004).

In other words, nurses choose which of the patients' competing needs to address first and how to distribute their time for patient care in ways that meet patients' needs and offer the best possible outcomes (Lake et al., 2009).

Numerous studies have investigated implicit rationing of nursing care as an *outcome* despite the most often-rationed nursing care activities being those that receive lower priority, as they require either more time or unpredictable amounts of time to complete and are less likely to be audited ([Blinded], Jones et al., 2015, [Blinded]). Few research teams have investigated the actual process of implicit rationing of nursing care, i.e., nurses' experiences setting priorities and making decisions regarding nursing care rationing (Garcia Guerrero, 2019, Hendry and Walker, 2004, Johansen and O'Brien, 2016, Suhonen et al., 2018). There is some suggestion that nurses might not always approach clinical decisions or priority-setting systematically (Sundin et al., 2014); instead, the process might be intuitive, based more on tacit knowledge and experience than on formal criteria (ONeil et al., 2005, Stanfield, 2015, Whalen et al., 2016). For instance, while nurses' decision-making is known to depend on individual factors (e.g., personal experience and knowledge), organizational factors (e.g., nursing practice environment, availability of nursing protocols) also contribute significantly (Nibbelink and Brewer, 2018). Because of the potential implications, it is vitally important that we deepen our understanding of implicit rationing of nursing care. For instance, to develop appropriate countermeasures and to prevent and/or reduce the levels of rationed care, we must first strengthen our understanding and ability to measure it. In order to deepen our understanding on the process of setting priorities and making decisions regarding nursing care rationing, with this study we aimed to explore nurses' experiences with implicit rationing of nursing care in acute-care hospitals.

2 METHODS

2.1 Study design

We conducted a qualitative study using Thorne and colleagues' approach to interpretive description as a methodological framework for qualitative health research (Hunt, 2009, Thorne, 2008, Thorne et al., 2004). Their vision of interpretive description as non-categorical methodology emerged in response to a call for an alternative way of generating grounded clinical practice-focused knowledge that could move qualitative inquiry beyond simple description to a more abstract genre (Thorne et al., 2004). The interpretive description approach acknowledges the researcher's theoretical and practical knowledge of the phenomenon under study. Moreover, detailed line-by-line coding is sidestepped in favor of broad questions (Hunt, 2009, Thorne, 2008, Thorne et al., 2004).

2.2 Participants and research context

As a convenience sample, 31 frontline nurses (i.e., registered nurses, nurse assistants) and 19 ward nurse managers were recruited from a range of acute care (i.e., medical/surgical, intensive care, rehabilitation, psychiatric and pediatric) units. As implicit rationing of nursing occurs at hospitals' micro-level (the patient-nurse interface), we aimed to capture both frontline nurses' and nurse managers' experiences with this phenomenon. For privacy reasons it was not possible for us to inform any of the prospective participants directly; therefore, the first and last authors ([Blinded]) invited the 75 ward nurse managers from the seven participating hospitals by emailing study information to their chief nursing officers, who passed that information to them along with assurances that participation was voluntary and that participants' informed consent would be collected from each participant on the day of their interview. The ward nurse managers were asked to participate in the interviews and to forward a separate invitation e-mail to the individual frontline nurses on their units. Interviews were arranged with all who responded to the invitation. The participants were then

interviewed at the hospitals after they had given their oral and written consent to be interviewed. The only criterion for selection was that frontline nurses and ward nurse managers had at least 6 months of clinical experience. As this was a qualitative study, sample size was monitored continuously to identify when saturation (i.e., replication of data already collected) was reached (Thorne, 2008). Table 1 describes the study participants by gender, mother language and professional experience.

[Please insert Tab. 1 here]

The study was conducted in the seven acute care hospitals of the *South Tyrolean Health Trust*. South Tyrol is an autonomous province in Northern Italy with a total population of 524,256 people. The ethno-linguistic mix is 69% German- and 26% Italian-speaking (Provincial Statistics Institute, 2016). Italy's national health plan (*Servizio Sanitario Nazionale*) is funded through direct taxation and provides universal coverage for hospital and medical benefits. However, the public healthcare system is decentralized. While the national government is responsible for funding the overall system, each of Italy's 20 regions controls the functions of health services within its jurisdiction through a local Health Care Unit, which handles a range of day-to-day management services. Local Health Authority Services (*Azienda Sanitaria Locale*) provide acute and primary care. The South Tyrolean Health Trust is one such service. The autonomous province spends 1.2 Billion Euro (23% of annual budget in 2017) for healthcare. The seven acute-care hospitals of the *South Tyrolean Health Trust* employ >9,200 people and account for 1,731 acute care beds, facilitating 73,600 annual recoveries, with a mean length of stay of 6.4 days (www.sabes.it/de/578.asp). Nursing care is provided by registered nurses (i.e., since 1999, with three years' undergraduate study, leading to a Bachelor's Degree) and nursing assistants (i.e., with two years' vocational training).

2.3 Data collection

We conducted a total of eight focus group interviews – four with frontline nurses and four with ward nurse managers – between November 2016 and March 2017. An interview guide was developed based on findings from a previous survey study on implicit rationing of nursing care ([Blinded]). Our pilot study to evaluate the interview guide with nine 3rd year nursing students at the [Blinded] resulted in several questions being rephrased. The guide was then left unchanged throughout the interview process. The semi-structured interviews opened with a short introduction to the topic (e.g., definition and explanation of “implicit rationing of nursing care”). The interview questions focused on the following aspects: experiences as frontline nurses/nurse ward managers with implicit rationing of nursing care on their unit; perceptions regarding clinical decision-making and priority setting; and perspectives on prioritization of patients and/or care activities.

As similar responses were repeated and saturation reached after the first round of interviews, there was no need for further rounds. So that all participants could express themselves in their mother language, the interviewers ([Blinded]) offered the option of participating in either a German- or an Italian-language focus group interview. The audio-taped interviews took place at a convenient location (e.g., a meeting room) within each hospital and lasted 40 – 75 minutes. After each interview, the first and last authors wrote supplementary field notes and developed “cognitive maps”. Taped interviews were transcribed verbatim by an administrative collaborator with considerable transcription experience. [Blinded] read through each transcript to allow emerging insights to be incorporated into the ongoing data collection (Hunt, 2009, Thorne, 2008, Thorne et al., 2004).

2.4 Data analysis

Analyses were informed by authors’ research interests and experience regarding patient safety, quality of care, nurse staffing and rationing of nursing care. All authors are registered

nurses with multiple years' clinical experience in acute care settings. Three ([Blinded]) are PhD-holding senior health services researchers; the fourth ([Blinded]) is a PhD-student. One ([Blinded]) is a professor of acute care nursing. A thematic analysis approach was used, following the phases described by Braun and Clarke (Braun and Clarke, 2006). As thematic analysis is very flexible and facilitates distinguishing, identifying and interpreting themes, i.e., significant patterns in the data, we considered it appropriate for use with interpretive descriptive methodology. Overall, the thematic analysis was guided by one analytic question: What experiences, perception/s drive the process of nurses' implicit rationing of their care? After reading and re-reading the transcripts (familiarization with the data), the initial coding phase started with the first and last authors ([Blinded]) reading the transcripts separately and coding for patterns and themes, labelling paragraphs that contained information regarding points discussed. In the next phase, the two analyzed the initial codes together, sorted them into potential themes and discussed their meanings and emerging patterns with the aim of reaching a shared understanding/agreement.

For the next step, all relevant coded data extracts were collated within the identified themes and mind-maps used to meaningfully organize any emerging themes. The two authors reviewed the identified themes for internal homogeneity (i.e., meaningful cohesion of codes) and external heterogeneity (i.e., clear distinctions between themes), re-coding the data extracts as necessary. They further refined and defined the themes by identifying their individual and collective essence (Braun and Clarke, 2006). Conceptual themes were derived inductively from analysis within and between individual interviews (Hunt, 2009, Thorne, 2008, Thorne et al., 2004). We used MAXQDA 2018 (VERBI Software, 2017) for data analysis. Finally, this process led us to develop the three interconnected themes that we present below: a) maintaining stability amidst complexity; b) applying strategies to limit rationing; and c) nursing care between ideal and reality. Each theme contains sub-themes pertaining to factors

considered influential vis-à-vis the processes involved in nurses' decision-making, priority setting and rationing of nursing care.

2.5 Ethical consideration

The regional ethical committee at [Blinded] approved the research project described here (Nr. 73-2015; Prot. 0080044-BZ); the study was conducted in accordance with the Declaration of Helsinki (World Medical Association, 2013). We obtained both oral and written informed consent prior to all interviews. To protect participants' confidentiality, none of our records, including interview transcripts, noted their names or other identifiers. We presented all results anonymously and limited data access exclusively to the research team.

3 RESULTS

In this section, we present our findings on front-line nurses' (IN) and ward nurse managers' (IWM) day-to-day experiences with implicit rationing of nursing care on their units. The fact that rationing occurs reveals a gap between the ideal and the reality of providing nursing care. According to the study participants, implicit rationing occurs when nurses have difficulty maintaining stability in complex situations. At the micro-level, nurses described various strategies they applied to prevent or reduce the need for rationing. Within each theme, we identified subthemes that nurses described as important factors influencing their decision-making, priority setting and rationing decisions (see Fig. 1).

[Please insert Fig. 1 here]

3.1 Maintaining stability within complexity

Clinical practice in acute-care settings is highly complex. Within *the complexity of* patient needs, care and work processes, and health care technologies, nurses seek to create and maintain stability within their environment. Stability is supporting by keeping to daily

routines that help nurses exert control over their practice, for example by structuring the diverse and often competing demands of their patients and their work environment.

Keeping to a daily routine

In order to maintain stability under complex or otherwise stressful conditions, nurses reported following *a predetermined daily routine* of nursing care (IN2). By keeping to a daily routine, nurses seek to ensure that their patients receive all essential care activities. In the interviews, one mentioned aspect of daily routine was organizing nursing care around fundamental care activities – *addressing the basic needs, because we have many patients that are not able to wash, to eat or to clothe themselves* (IWM2). In the morning shift, *patients first do the morning care, they are washed and have breakfast* (IN2). While routinization is important to maintain stability, the daily routines described by the participating nurses reflected a more task-focused than person- or relation-centered approach. For example, to distribute care activities to the patients on their units, some nurses are routinizing their nurse-to-patient interactions. One nurse ward manager described how the nurses on her ward adhered to a routine focusing on nursing tasks:

On a normal day we start in the morning by measuring the blood pressure; then we take care of the oral therapy and I start at room 1. If there is nothing special, then I go room by room, from room 1 to 7 and then from room 8 to 13 (IWM3).

Organizing nursing care

Nurses organize their work in a way that allows continuous patient care while leaving them the flexibility to maintain stability despite potentially destabilizing factors. One nurse ward manager reported that their unit was organized ... *in groups, i.e., the unit is divided into group 1 and group 2* (IWM3), where all of the nurses in each group care for all of the patients allocated to their group. Most nurses reported working ... *12-hours shifts, whereby everyone takes care of 10 to 12 patients* (IN2). Despite the heavy workload, nurses generally preferred 12-hour shifts, as with a longer shift ... *it is easier to prioritize and do postponed activities*

(IN2). This suggests that organizing nursing care that fosters patient care continuity (i.e., shift scheduling) is a crucial prerequisite to applying strategies such as “postponing”. 12-hour shifts were perceived as better to assure continuity of care, to limit rationing of nursing care, and to offer flexibility regarding the timing of care. Unlike 12-hour shift the increasing use of nursing assistants in acute-care settings was perceived mixed from registered nurses with regard to organizing nursing care in order to provide continuous patient care. One described them as a valuable resource within the care team:

*Nurse assistants, since we have them, we have more resources.
[...] Caring, mobilizing, before we did everything ourselves and
there is a difference, because I have to do only the therapy and
dressing changes and have more time for the patients” (IN2).*

Other impressions were more critical. E.g., one registered nurse noted that nurse assistants *often have more contact with the patients than we do* (IN1). In this case, the concern was that changing the skill mix and the differentiation of nursing care negatively impact the continuity of nursing care. For instance, registered nurses are inclined more towards rationing direct patient contact, as nursing assistants might become the primary contact person. A nurse ward manager remarked that, where nurse assistants are overused, the continuity of care suffers, *because we split up nursing care, ... [and] I have the problem, who has the overview, who is the primary contact person?* (IWM4).

Reacting to patients’ instability

Whatever nurses’ routines may include, their goal is to be able to manage sudden increases in complexity, i.e., acute or critical situations, *when patients’ survival is at stake* (IN3). *We always have acute events on our unit, and we give priority to patients who are unstable or patients with high care needs* (IN1). There was acknowledgement that this might lead to rationing of care for more stable patients, e.g., those in post-acute phases of their

hospital stays. One nurse summarized this process and its consequences as follows: *Sometime [...] we don't look after all patients in the same way – more often to patients that need more assistance and the others get a bit lost* (IN3). One term that was often used by Italian-speaking nurses to revise patients' charts to reflect higher levels of acuity and/or intensity of nursing care needs was *criticità*, denoting criticality or instability. Although care priorities are based on patients' relative levels of stability, the only formal criteria mentioned in the interviews were patients' pathologies. *When there are patients with more severe pathologies, more things come together, more variables determine the criticality* (IN1). Similarly, another nurse reported that *the [overall] health state of the patient determines their priority* (IN3). In cases where multiple patients had higher acuity and care needs, prioritization was described as situational (*therefore it is evaluated in the moment if and how to manage* (IN1)) and intuitive (*intuition, it can be estimated* (IN3)) rather than based on formal criteria.

3.2 Applying strategies to limit rationing

As special measures become necessary to maintain stability amid the complexity of their work, nurses implicitly ration necessary care activities. Yet, they report applying various strategies to balance out this deficiency and to limit the levels of rationed nursing care. Of the participants' strategies to limit the levels of care rationing, the most common were reducing quality before quantity, postponing and working overtime, and working together as a team.

Reducing quality before quantity

To limit the levels of care rationing, nurses reduce the quality of their care, thereby saving time so that they can complete the full range of their planned nursing care activities and keep to their routines. In the focus interviews, the rationale was explained succinctly: *The quantity of activities remains, but the quality is reduced to a minimum level....It's about how we do it, not if we do it* (IN1). Reducing the quality was commonly mentioned regarding the relational aspects of nursing care:

You have to be quick, some activities you have to cut, such as relationship, to save time. It is not nice if you reduce the time to explain things to a patient, who might be a bit slow to understand, but you have to.... You have to save time on these activities (IN1).

Postponing and working overtime

The practice of reducing quality before quantity is not always sufficient to provide the necessary care within the required time. This leads to two options that are often combined: postponing nursing care and working overtime. One nurse reported that *I leave it for tomorrow or for the next shift (IN2)*. The expected time needed for the task drives the decision to postpone: *If I have a lot to do, I will not start something that takes me 20 minutes, I will postpone it (IWM3)*. Dressing changes were cited as an example of this; *Normally we do this in the morning, but when it is not possible, we change the dressing in the afternoon (IWM3)*. Some nurses reported that postponing to the next shift was seen as normal: *I see it like a wheel and I'm there to work and I come and I continue what the one before me has not finished. I don't have the feeling of doing something bad when leaving things to the next person, because I didn't have a coffee break for 3 hours, yet did not have the time to do it (IN3)*. Others reported working overtime to avoid postponing care, seeing it as their duty: *I want to finish my work and stay an hour longer in the evening. Then 12 hours will become 13 hours... (IN2)*. Sometimes, the decision to work overtime is driven by negative feelings such as guilt: *If you know that they in the afternoon will be swimming [in work] more than those in the morning, you stay longer. That's how it is (IN4)*. Another possible motivator to work overtime 'to get things done' is concern about being blamed by colleagues: *But you don't want to leave it to the nurse that is coming after you, because then she comes in the evening and you think, 'if I were coming now and all this had not been done'...' (IN3)*.

Working as a "Team"

A third important strategy to prevent or limit rationing of care was working as a team, which requires *first of all, flexibility of the staff (IN1)*. The team was described primarily as

the nursing team. *If there is something [to be done], we work together. The others take care of the patients. Or if you say, 'I'm busy now with this patient, please have a look after my patients if they call the bell or if they need something'* (IN2). Even the nurse ward managers mentioned helping out, especially for communication and providing information to patients and their relatives. *Often as a nurse ward manager I help out with what they do not get done, most often tasks related to communication* (IWM2). *If I have office time, they can call me if there is a lot to do* (IWM3). Nurses saw this level of support as an advantage: *[We appreciate it] that the nurse ward manager compensates when there is a lot to do during shifts* (IWM3). Other allied health professionals also participate in care activities as part of the *ad hoc* interprofessional team: *We ask the physiotherapists to help mobilize the patients, if we have not enough staff* (IN1). Moreover, the family members and/or 'badante' (home care workers) were seen as useful resources and enlisted to provide the necessary care, "...when the patient is complex, when he is heavy (demands a high level of care) we more and more involve the informal caregivers, the 'badante' or the children" (IWM1). However, their involvement in the provision of nursing care during the hospital stay has its limits: *"you can involve them only for confused patients, ... you cannot say to them, 'help me to change a catheter or so'"* (IN4).

3.3 Nursing care between ideal and reality

The interviews contrasted the gap between the ideal and the reality of nursing care. The nurses' comments highlighted a tension between the work they are educated, registered and employed to do and the tasks they actually perform. Implicit rationing of nursing care highlights this tension, commonly describing this in terms of (un-)safe and (non-)patient-centered care, and the performance of (non-)nursing tasks.

Providing (un-)safe care

Nurses made the point that „*the safety of our patients and our own safety have priority*” (IN1), acknowledging that the primary goal of nursing care should be that „*first of all, patients need to be safe*” (IN1). In their daily clinical work, nurses prioritize their nursing tasks so „*the health and safety of the patients is not jeopardized*” (IN3). On the other hand, several also reported that, in clinical practice, *sometimes borders are crossed* (IN4), i.e., safety practices are violated due to a lack of time. For instance, an RN might delegate a nurse assistant to do a task...[such as] *flushing an IV line, which is our competence* (IN4).

Providing (non-)patient-centered care

Carrying out care activities, where nurses have [direct] contact with the patient and everything that has to be done at bedside has priority (IN3), one nurse remarked that if the patient has pain, this is more important than to mobilize him or to do mouth hygiene. Pain and IV medication are priorities for me (IN2). Activities more distant from the bedside and the patient, tended to receive lower priority. For example, documenting, writing and evaluating take time that is often not there anymore (IN3). However, patient care priorities are set by nurses, not in collaboration with the patients. This is likely a side-effect of routinizing nurse-to-patient interactions to maintain stability and follow a task-focused approach. If patients were actually at the center of all care activities, their care could be planned and provided in consultation with the patient and discussing the priorities (IN2).

Performing (non-)nursing tasks

Performing all planned nursing care at high quality in all cases within the hospital setting was seen as nearly impossible challenge, as *nurses are dependent on others* (IN3) and their decisions and priorities are influenced by the prevailing structure and organizational culture. For the most part, the nursing care has to mesh with other hospital-defined processes and schedules: between the hospital directors and the patients, nursing care is the *last link in the chain* (IN2). Nurses *have to prepare the patients for visits and therapies* (IN3), organizing

and providing care around and between other diagnostic and therapeutic procedures. Nurses reported often completing tasks such as *logistics, preparing materials, distributing and collecting meal plates, phone, bureaucratic and administrative tasks, fetching materials and infusions from the magazine ...[etc.], things that don't have to do with nursing* (IN1). Although some of these tasks fall outside the scope of nurses' clinical practice, they often take precedence over nursing-specific tasks. In particular, bureaucratic and administrative tasks represented a neuralgic point in the interviews. Although these activities are considered crucial to professional and high-quality nursing care, these "indirect care" activities are also often rationed. However, nurses are additionally burdened with performing administrative work for the physicians:

we don't have a secretary, so we do a lot of bureaucratic things for the physician and some we cannot postpone (IN2). If the physician is present on the ward, I have to help him with organizational things and the nursing care remains undone (IN3).

Although nurses are health professionals, due to a lack of power and autonomy some feel obliged to *do bureaucratic things that we do not necessarily have to, because the physician could do them* (IN3).

4 DISCUSSION

The study aimed to explore how frontline nurses and nurse managers experience the phenomenon of implicit rationing of nursing care on their units. The participating nurses described three interconnected themes: maintaining stability within complexity; applying strategies to limit rationing; and nursing care between ideal and reality. Within each theme, we identified subthemes that nurses described as important factors for decision-making, priority setting and implicit rationing of nursing care.

One major novel finding that emerged from the focus group interviews with frontline and nurse ward managers was that implicit rationing of nursing care happens in line with nurses' primary goal to maintain stability amid the complexity of caring for often-unstable patients within complex contexts. The balance between complexity and stability is of key importance to the survival of individuals, organizations and even ecosystems (Landi et al., 2018; Thompson et al., 2016). Within the complexity of healthcare organizations, nurses might see it as their duty to maintain some level of homeostasis. In our interviews, nurses described fundamental care activities as part of a stability-maintaining daily routine.

As a result, technical activities to stabilize patients generally receive higher priority than relational activities with more stable ones. Patient care activities that are related to immediate physical needs helping to keep a daily routine (e.g., patient surveillance, timely administration of medications) appeared to receive the highest priorities. Activities for which the required time and effort are difficult to estimate, such as talking to patients, educating them and their families or complying with bureaucratic demands (planning functions), seem to receive the lowest ([Blinded], Ball et al., 2014). Our qualitative findings confirm previous international cross-sectional studies' common observation that nursing activities addressing patients' emotional, educational, mobility and hygiene needs were commonly rationed (Mandal et al., 2020).

Our findings extend those reported in the international literature on implicit rationing of nursing, as nurses described much or most of their care as routinized task behavior. While routinization might be useful to maintain stability and the capacity to react to increased complexity, nurses' responses indicated that this stability comes at a high price. They face the dilemma of what Lipsky called "street-level bureaucrats", i.e., public service workers who are supposed to help people or make decisions on a case-by-case basis; yet the structure of their jobs makes this impossible (Lipsky, 1980). Acting as "street-level bureaucracy", nurses attempt to provide all care tasks they consider necessary to their patients, often by reducing

quality to a minimum (Lipsky, 1980). The rationing of quality (i.e., patients' basic human need for relational care activities) before the quantity of care might lead to negative individual patient experiences with nursing and health care (Rathert et al., 2013).

To take this system of prioritization to an extreme level, Richards and Borglin used the term “shitty nursing” to describe their worrying personal experiences with nursing—involving either inattention to or complete neglect of fundamental personal needs such as mobility, nutrition or even hygiene (Richards and Borglin, 2019). More qualitative research is needed to increase our understanding both of patients' expectations—as consumers of modern health care—and of which care activities add the most value, i.e., should be afforded the highest priority. Such an appraisal could help to start a more open discussion of implicit and otherwise non-transparent rationing at all organizational levels and to orient, value and incentivize nurses to return their focus and attention to the core values of their profession (Richards and Borglin, 2019).

In our study, nurses reported on their attempts to prevent or limit rationing of nursing care. And while resource scarcities, i.e., low staffing levels, are firmly linked to higher levels of “unfinished care” (Griffiths et al., 2018), before rationing or omitting care activities, nurses often apply mitigating strategies such as reducing quality before quantity, postponing and working overtime, or teamwork. Also, a recently published qualitative study found that nurses do not readily consider their accountability when deciding which care tasks to omit or delay; instead, their priorities focus on the patients and the organization (Harvey et al., 2018), i.e., the available data indicate that nurses give their patients' and their organizations' stability higher priority than the possibility of being punished for rationing their care. Many even sacrifice wages to conceal their inability to finish on schedule. Harvey et al. (2018) observed that almost half of their interviewed nurses reported routinely staying after shifts to complete their work without claiming for overtime or time off in lieu. Further research will be

necessary to define the limits of their perceived personal responsibility regarding their patients, their employers, or even other members of their care teams.

Problematically, our interviews also revealed that professional nurses routinely perform non-nursing tasks such as administrative/bureaucratic activities to support physicians, even when it leaves them short of time to complete their patient care. Rationing in nursing is ubiquitous, embedded in the hospitals' and units' structure, culture and work environment, posing serious implications not only to patients' safety but to the professional health and philosophical base of nursing (Mandal et al., 2020). 2020 is the International Year of the Nurse and the Midwife (WHO, 2020). Despite considerable advancements, e.g., nurse-led care (Laurant et al., 2018), health care systems still underestimate the importance and value of nursing care. In addition to exposing the gap between ideal and reality, implicit rationing responds to and enables what Harvey et al. (2020) described as the incongruity between professional standards and organizational resources.

In our interviews, nurses reported performing non-nursing tasks, e.g. bureaucratic and administrative tasks for physicians, that are not related to nursing care. While these tasks might be important for the stability respectively homeostasis of the organization, it raises several questions about the efficient use of nurses' time and energy when performing tasks below their skill level in times of global nurse shortages (Drennan and Ross, 2019). Moreover, this raises also important questions regarding nurses' self-understanding, self-awareness and professional identity. A mature profession cannot continually blame contextual factors and must shoulder some of the responsibility for its own problems (Richards and Borglin, 2019). However, healthcare tends to be very traditional and hierarchical and nurses still often lack autonomy and power to do anything to change the situation. Healthcare organizations need to invest in structural empowerment and create work environments that permits and sustains the full expression of nurses' skills and knowledge to prevent or limit implicit rationing of nursing care (Desmedt et al., 2012).

Implicit rationing of nursing care is considered to be an observable, measurable, and objectively quantifiable negative outcome within patient care. However, several well-known conceptual and methodological challenges in studying this phenomenon have been summarized (Vincelette et al., 2019). This study of nurses' experiences with it revealed insights that might help to reflect on its conceptualization, operationalization and measurement, as well as other concepts summarized under the umbrella term of "unfinished nursing care". First, the conceptual framework on implicit rationing of nursing care assumes that the processes of decision-making and priority setting are embedded in the nursing process (i.e., assessment, planning, implementing, evaluation), which presupposes an established decision-making model in the nursing field. In our study, though, nurses noted that in reacting to patients' instability, priority setting and care rationing follow not the logic of an analytical model, but their intuition (Banning, 2008, Johansen and O'Brien, 2016, Pretz and Folse, 2011). Nurses formulate an opinion of the situation at hand, then, without reference to professional guidelines (as none exist on this topic), prioritize which care processes are necessary, at what quality, for which patients. While it is known from the literature that nurses integrate intuition, analysis and synthesis alongside objective data in their daily clinical work (Melin-Johansson et al., 2017), further qualitative research is necessary to expand our knowledge of nurses' intuitive and situational decision-making and priority-setting in the context of implicit rationing of nursing care. Second, before rationing care activities – thus leaving care unfinished – nurses apply strategies such as rationing the quality of their work and/or postponing care activities, e.g. until the next shift and/or nurse. In comparison to implicit rationing of nursing care, the broader concept of missed care considers all activities that are either partly or completely missed or delayed (until a later shift) as omission of care (Kalisch et al., 2009). Still, performing care at a lower quality, postponing (within the same shift) or delegating activities are not yet reflected in either of these concepts. As the phenomenon's current conceptualizations and operationalizations might actually impair

attempts to measure it, these aspects need to be addressed via further qualitative research (e.g., expert consensus meetings). Doing so will inform the development of more precise measurements, e.g., to analyze routinely reported data.

One general weakness in this field—as in many areas of research—is that most quantitative studies are cross-sectional and rely on self-reported survey instruments. One result is a strong need both for longitudinal studies (Dhaini et al., 2019) and for objective measures to be used in electronic documentation and nursing care reporting systems (Vincelette et al., 2019). As Bail and Grealish recently proposed, such instruments could even be automated and applied continuously at the individual patient and shift level for monitoring and benchmarking purposes (Bail and Grealish, 2016).

4.1 Strengths and limitations

This study's main weakness arose from our use of a convenience sampling strategy for frontline nurses and nurse managers, as this does not confer transferability. However, the research question guiding our data analyses did not involve identifying differences, but capturing the complementary perspectives of frontline nurses and nurse ward managers. While frontline nurses appeared to favor a more individual perspective, nurse ward managers showed more consideration for the organizational perspective of implicit rationing of nursing care.

Among its strengths were the number of focus-group interviews. By providing in-depth information from various individuals representing diverse and valuable experiences, perceptions and perspectives, these strengthen our findings considerably. Also, the findings of a study applying an ID approach are not a list of isolated themes, but a synthesis of main themes and patterns relevant to the phenomenon that experts in the area will acknowledge as persuasive (Hunt, 2009, Thorne, 2008, Thorne et al., 2004). Without offering firm assurances for transferability, we note that most of our findings concur with previous studies on this

topic, and believe that the principles they represent are widely applicable. Still, while these findings might be somewhat transferable, differences in regional nursing care, health care systems and public policy limit their applicability to other cross-cultural care contexts.

5 CONCLUSIONS

This study aimed to explore nurses' experiences with implicit rationing of nursing care in acute-care hospitals. The study found that in the absence of guidelines on implicit rationing of nursing care, nurses rely on intuitive and situational processes of decision making and priority setting. This was seen to manifest in implicit rationing of nursing care that was revealed in three interconnected themes: a) maintaining stability amidst complexity; b) applying strategies to limit rationing; and c) nursing care between ideal and reality. According to the study participants, implicit rationing of nursing care represents nurses' way of maintaining stability for their patients and their units when they lack the time to complete all necessary tasks at a high standard. Nurses described their attempts to prevent or limit the necessity to ration care by applying strategies including postponing tasks or reducing their quality. When these are not enough, rationing bridges the gap between the ideal of nursing care and the reality. The finding that quality may be an earlier casualty of implicit rationing than quantity challenges us to broaden the current focus of how care rationing manifests. By providing new insights into this complex phenomenon, it is hoped that this study will lead to a more open discussion of implicit and otherwise non-transparent rationing at all organizational levels. Finally, this study will help to inform the development of interventions to support nurses' priority setting limit rationing of care at the bedside.

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Conflicts of interest

None

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Figures and Tables

Table 1. Gender, mother language and professional experience of study participants

	Unit managers (n=19)	Registered Nurses / Nursing assistants (n=31)
Gender (n - female)	12	28
Mother language (n - German)	16	27
Professional experience (years)		
Total experience (median years)	27	19
Median years as unit manager/ nurse on the current unit	16	15

Figure 1. A final thematic map, showing the final three main themes and sub-themes within the process of decision-making, priority setting and rationing of nursing care

