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Article type   : Original Article

Developing Policies and Actions in Response to Missed Nursing Care: A Consensus Process

Running title: Missed Nursing Care Policies and Actions

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Abstract

Aim. To support the development of appropriate policies and actions in the field of Missed Nursing Care (MNC).

Background. There has been an ever-growing international debate on MNC, interventions that nurses have identified as necessary for their patients, but which for various reasons they are unable to provide or are forced to delay. Despite MNC's relevance, its translation into policies and actions has not been documented to date.

Method. A Consensus Development Method was employed involving (1) a Nominal Group composed of experts in the field, policymakers, and the President of the Regional Nursing Professional Boards, and (2) 218 nurses appointed primarily at the managerial levels.

Results. A total of eight Consensus Statements were approved and organised in a series of sub-statements designed to: (1) Render the concept of MNC culturally acceptable in the Italian context, with the agreement that Compromised Nursing Care (CNC) is the best term to be used in this field, as a synonym for MNC; (2) Measure CNC as a strategy to increase patient safety; (3) Select an appropriate CNC measurement tool; (4) Optimise CNC measurement; (5) Conduct effective CNC data analysis; (6) Design and implement interventions to prevent and/or minimise CNC; (7) Assess and disseminate findings on interventions' effectiveness, and (8) provide final remarks on the way to move forward.

Conclusions. We developed a process to introduce the phenomenon of MNC in the Italian culture and agreed firstly on the term Compromised Nursing Care, which better reflects MNC's meaning according to the context, and facilitates an open discussion on the phenomenon both within and outside the profession. The following Consensus Statements emerged represent a systematic approach, starting from the measurement and finishing with the re-measurement of the occurrence of MNC after having implemented concrete actions.

Implications for Nursing Management. The approved Consensus Statements can guide decision-makers to develop concrete policies and actions that promote the improvement of quality of care and patients' safety by minimising and/or preventing MNC's occurrence.

Keywords: Consensus development process; consensus statements; implementation process; missed nursing care; nursing care; policy; rationing of nursing care; tasks left undone

1. INTRODUCTION

During the past several years, there has been an ever-growing international debate on Missed Nursing Care (Kalisch, Landstrom, & Hinshaw, 2009), Tasks Left Undone (Aiken et al., 2001) and Rationing of Nursing Care (Schubert, Glass, Clarke, Schaffert-Witvliet, & De Geest, 2007). Despite their different conceptual definitions, these terms are used interchangeably (Jones, Hamilton, & Murry, 2015) because all refer to interventions that nurses recognise as necessary for their patients, but which they are unable to provide or are forced to delay for various reasons (Fitzpatrick, 2018).

Missing or rationing nursing care, or leaving nursing tasks undone have been identified as process measures and plausible indicators of hospital nursing care quality (VanFosson, Jones, & Yoder, 2016; Ball, Murrells, Rafferty, Morrow, & Griffiths, 2014). Moreover, they also have been recognised recently as mediators in the association between nursing staffing levels and patients' outcomes (Griffiths et al., 2016). As a consequence, with respect to patients and healthcare systems, Missed or Rationed Nursing Care or Tasks Left Undone can serve as early indicators of the risk of adverse events (e.g., pressure ulcers, medication errors, hospital acquired infections) attributable, for example, to recurrent omitted ambulation, medication administration, or handwashing (Fitzpatrick, 2018). Furthermore, the occurrence of tasks left undone has been associated with decreased professional satisfaction and motivation, and increased intention to leave the nursing profession (e.g., Rochefort & Clarke, 2010).

Despite their relevance, the translation of these phenomena into concrete actions or interventions within the nursing profession and healthcare settings at the clinical, educational, and managerial levels, have not been documented to date (Fitzpatrick, 2018). Translating evidence into action with the aim of increasing patients' quality of care (Cairney & Oliver, 2017) has been estimated to require approximately 17 years to be accomplished (Kanter, Shottinger, & Whittaker, 2017). Policy development and implementation have been documented to be valuable in overcoming barriers that prevent evidence translation; however, values (e.g., cultural influence) and politics (e.g., economic influence) have been reported to affect policy development and implementation (Phua & Hue, 2015). Thus, research and

consultation have been established as key steps in the process of policy development designed to translate evidence into practice effectively (Black et al., 1999; James & Warren-Forward, 2015).

As a first attempt to expand the debate and translate into practice the evidence available on Missed Nursing Care, Rationed Nursing Care, and Tasks Lefts Undone, hereinafter Missed Nursing Care (MNC) as an overarching term, a consensus development process was undertaken within the RANCARE COST Action project. Reporting here the process and debating the findings achieved in the Italian context can inform more global policy development processes in the field.

1.1 Background

The MNC concept was introduced in literature approximately 15 years ago. Originally, the concept, as well as its measurement instruments, was developed in the US, as Tasks Left Undone (TLU) by the University of Pennsylvania School of Nursing's Centre for Health Outcomes and Policy Research (Sochalski, 2004). Several years later, researchers in the School of Nursing at Michigan University established the Missed Nursing Care concept and instrument (Kalisch, 2006). In the same year, Rationing of Nurses Care was developed at the University of Basel, Switzerland (Schubert et al., 2007).

With the increased body of knowledge available, the concepts and related instruments mentioned above have been disseminated in other English and non-English-speaking countries and have attracted recognition worldwide (e.g., Blackman, Papastavrou, Palese, Vryonides, Henderson, & Willis, 2018; Bragadóttir, Kalisch, Smáradóttir, & Jónsdóttir, 2015; Papastavrou, Andreou, Tsangari, Schubert, & De Geest, 2014). Italian researchers also have contributed to this dissemination process, firstly by publishing an overview of the Missed Nursing Care concept in Italian (Sist et al., 2012), and then validating the MISSCARE survey tool (Sist et al., 2017; Sist et al., 2012) that allowed it to be used as a measurement both by nurses and students (Bagnasco et al., 2017; Palese et al., 2018; Palese et al., 2015).

As a consequence, over the years, concepts that define the gap between what nurses plan for their patients and what they actually deliver have been translated into tools that measure the phenomenon in practice and have been established and disseminated rapidly around the World (Jones et al., 2015).

Increased evidence has also been found with respect to factors that affect MNC's occurrences, most of which are related to the care environment's structural dimensions, such as lack of human resources and support/supplies, communication difficulties within the team, and the occurrence of unexpected events, such as urgent patients' admissions (Bassi, Tartaglini, & Palese, 2018). Therefore, MNC prevention requires not only safe staffing levels, which have been established in some countries as mandatory nurse-to-patient ratios (Griffiths et al., 2018), but also an in-depth consideration of the process of care delivery in addition to structural elements (Bassi, Tartaglini, & Palese, 2018).

However, although progress has been made in the dissemination process and the understanding of mechanisms underlying MNC's occurrence that allow both preventive and treatment interventions to be designed, no attempts have been made to date to translate the underlying science for practitioners (Fitzpatrick, 2018). Moreover, despite the fact that MNC can affect patients' outcomes significantly, no credible policies or actions have been documented to date in this context. On the contrary, as Scott and colleagues (2018) reported recently, the predominant and pervasive assumption policymakers and health service managers make is that nurses are continuing to provide full care despite reduced staffing levels, increased patient turnover, and nursing care's acuity and complexity.

Translating and implementing such evidence implies integrating new knowledge in a specific cultural, professional, and healthcare context (Rabin et al., 2012) and furthermore, assessing the extent to which the new knowledge is consistent, sustainable (Damschroder, Aron, Keith, Kirsh, Alexander, & Lowery, 2009), and culturally appropriate (Hanney et al., 2015). When conducted effectively, the evidence translated into concrete implementation is accelerated (Rabin et al., 2012). From the managers and clinicians' perspective, top-down approaches have been documented to be unsuccessful, as the nursing profession and stakeholders have no 'ownership' of the policy (Haycock-Stuart & Kean, 2013). Policymakers must be convinced that a proposed action *will* work in the real world, where there are several influential factors, such as culture, values, history, and economic issues. Therefore, any new evidence should be translated preliminarily and developed further in the context given (Clancy, Glied, & Lurie, 2012).

In the past ten years, the European Commission has funded two large projects designed to strengthen the European Union (EU) collaboration to help countries develop their research capacity, and translate evidence produced into practice by informing sustainable policies. First, the RN4CAST (http://www.rn4cast.eu/about1.html, 2009-2010) was developed within the FP7-HEALTH-Specific Programme Cooperation: Health. Its intent was to study the way hospital care's organisational features affect nurse recruitment, retention, and patient outcomes by involving 12 EU countries originally, after which other countries replicated the study. The second was the RANCARE COST Action (https://www.cost.eu/actions/CA15208/#tabs|Name:overview, 2016-2020), an international nursing network composed of 28 EU and non-EU members with the same goal of promoting policy synergies by reporting nursing rationing's implications across countries and identifying innovative strategies to prevent MNC occurrence. Given the important implications for patients, nursing professionals, and the entire healthcare system, the project's intent is to support the development of appropriate policies and actions that prevent or minimise MNC's occurrence.

2. METHODS

2.1. Study aims and research questions

The aim of the study was to provide a set of Consensus Statements to assist in the development of appropriate policies and actions in the field of MNC. Three primary research questions were addressed:

(1) In accordance with its cultural, professional, and healthcare service context, what term best reflects MNC's meaning and should be recommended for use in the Italian language?

(2) In what way/s can MNC be measured effectively in the Italian context in accordance with its cultural, professional, and healthcare service specificity?

(3) What parameters should be considered in designing policies intended to prevent MNC in the Italian context?

The study process and findings are reported here according to the COnsolidated criteria for REporting Qualitative Research principles (COREQ, Tong, Sainsbury, & Craig, 2007).

2.2 Study design

A Consensus Development Method (Black et al., 1999; James & Warren-Forward, 2015).

2.3 The Consensus Development Method process

The process was designed and conducted in two steps and six phases, as reported in Figure 1.

2.3.1 Step 1: Identification

1. *Summarising the knowledge available and translating it into Italian.* A preliminary review of the literature was conducted in December 2017 without imposing any limitations on language and time. All relevant studies in the field were considered and summarised. The review was then published in Italian (Bassi et al., 2018) and disseminated among the authors' networks.

2. *Identifying MNC peculiarities in the Italian context.* Active participation in the RANCARE COST Action project (Supplementary Table 1) through its meetings, skype contacts, and working groups offered the opportunity to increase knowledge on the topic and develop insights into MNC similarities and peculiarities as disseminated in other cultural contexts and disciplines. Specifically, notes and insights were collected and recorded, for example, the need to adopt a neutral term to refer to MNC, given that a term with negative connotations could lead to blame that prevents an open discussion regarding the phenomenon.

3. *Identifying experts and summarising evidence and experiences in the field.* In February 2018, the need for a Nominal Group (NG: Halcomb, Davidson, & Hardaker, 2008) was identified and members were identified through a purposeful sample (Halcomb et al., 2008). Individuals that are particularly knowledgeable about or experienced with the MNC phenomenon as researchers, clinicians, managers, or

policy makers were identified and selected as NG members. The final NG included: (a) advanced educated Nurses who conducted the first research on the MNC field in Italy by translating and validating instruments (n= 3); (b) Nurse Managers who joined national or regional working groups designed to establish the compulsory nurse-to-patient ratios (n=4); (c) Nurses responsible for the Development of Nursing Care who have developed specific quality of care improvement projects in large National Health Service trusts (n=2); (d) University nurse educators whose experience in the MNC research field is recognised nationally and internationally (n=2); (e) a policymaker who is involved in developing a regional policy for nursing sensitive outcomes, and (f) the President of the Nursing Boards at the regional level as a stakeholder of MNC's professional implications. These members nominated a leader (AP) who interviewed everyone first by phone or via Skype individually, occasion in which everyone attempted to identify the most pressing questions regarding the development of appropriate MNC policies and actions in the Italian context. The main consensus questions were discussed and agreed upon and assigned to each member of the NG, individually or in pairs.

Then, they were invited to update the relevant literature and also consult the grey literature and/or regional MNC policies in the field. The notes containing the insights collected in the second phase of the process were sent to each expert or pair, and they were invited to prepare a summary that integrated all of the elements. Given the lack of expertise on policy development regarding MNC prevention or minimisation, two international experts (see authors, Australia and Cyprus) were included in the NG. The group met in May 2018 to harmonise the summary of the evidence that emerged, which was integrated with the NG's experiences and insights in the form of a PowerPoint presentation.

2.3.2 Step 2: Discussion and synthesis

4. Designing and conducting the Consensus Conference. The Conference was launched in February/March 2018 at the national level with a brochure describing (a) its goals, (b) profiles of the participants expected (clinical nurses, nurse managers, nurse educators, researchers, members of the Nursing Professional Boards, and policymakers), and (c) the publications recommended for individual

study before the conference (Bassi et al., 2018; Sist et al., 2017; Sist et al., 2012). The purpose of the Conference was to increase the understanding of MNC, examine its implications for practice, management, education, and research, and to establish a set of Consensus Statements as the basis for policy development in the Italian context. Conference participation was free and registration was closed after 180 people registered each day.

The Conference lasted 2 days and included: (a) short presentations that summarised the Consensus development process questions; (b) an open discussion among participants following the presentations; (c) the development of a set of Consensus Statements as principal recommendations, and (d) a description of sub-statements as specific actions that emerged from the presentations and the open discussion. Finally, at the end of each day, the NG leader presented five Consensus Statements to the audience, who voted by a show of hands (Campbell, Braspenning, Hutchinson, & Marshall, 2003). Full agreement on the 10 Consensus Statements and their sub-statements was achieved with 218 participants' approval (Supplementary Table 2). The first draft that reported all statements in Italian (Palese et al., 2018) was sent to all participants in November 2018. No substantial changes were recommended, and the comments were integrated into the final report.

5. *Consulting patients' representatives as stakeholders*. One representative group of patients was selected at the regional level, including all families of patients with dementia living at home or in nursing homes. In a meeting with the President, the Consensus Statements approved were discussed and agreed upon; one statement was revised in response to the Association's request, as shown in Figure 1.

6. *Refining the consensus statements and final approval*. The statements' wording was revised to ensure homogeneity and clarity, after which the NG gave final approval. The findings of the Content Validity Index (Di Iorio, 2006) examination was >0.95 and two statements that achieved <0.70 agreement were removed.

3. RESULTS

Eight Consensus Statements were categorised according to the questions that address the entire Consensus Development Process; these were also numbered in their sub-statements, as reported in Table 1. All Consensus Statements were supported with a rationale as reported briefly below.

3.1 Question 1: Which terms that best reflect the meaning of MNC should be recommended for use in the Italian language according to its cultural, professional and healthcare service context?

Missed Nursing Care is an expression that refers to a phenomenon in which nurses do not provide the nursing care activities that they planned rather than an individual professional's explicit intention to omit them (Bassi et al., 2018; Jones et al., 2015). However, from the etymological perspective, the phenomenon has been identified using different terms, each of which reflects a specific meaning according to the cultural, educational, professional, healthcare, and political context. Accordingly, no agreement on terminology has been reached at the international (Jones et al., 2015) and national level (Bassi et al., 2018). However, by translating the concepts available into Italian, all possible words assume a negative meaning: for example,

- MNC (in Italian = '*cure perse*') means that something is 'lost,' abandoned inadvertently, or the individual has failed to do something that should have been done (Vocabolario Treccani, 2018) (e.g., failing to turn a patient every 2 hrs);

- omitted nursing care (in Italian = '*cure ommesse*') reflects the omission of an intervention that should have been performed according to the nursing care plan (e.g., failing to monitor vital signs as ordered);

- incomplete nursing care (in Italian = '*cure incomplete*') suggests that a set of interventions required is not completed or finished (e.g., incomplete patient education);

- suboptimal nursing care (in Italian = '*cure sub-ottimali*') indicates that activities are provided at levels less than desirable (e.g., failing to administer medications within 30 min before or after the time scheduled);

- rationed care (in Italian = '*cure razionate*') implies that interventions are reduced to the bare minimum (e.g., minimising the time spent talking to and comforting patients/family caregivers), and

- violated nursing care (in Italian = '*violazioni nelle cure infermieristiche*') suggests that rules are transgressed (e.g., some practices do not conform to guidelines or legal, social, or moral rules).

Using words that have a significant negative meaning in the Italian culture can threaten an open dialogue on this phenomenon and its occurrence, causes, prevention, and elicit guilt, shame, and medico-legal implications within the nursing profession and healthcare systems, and, more widely, among patients and citizens (Bassi et al., 2018). Therefore, the need was identified to use a term able to express the concept of MNC in the Italian language and culture that the nursing profession, healthcare professionals, healthcare consumers, policymakers and the community at large would accept. The term identified was Compromised Nursing Care (CNC), which is tailored specifically for the Italian healthcare context, and the conceptualisation of which is considered synonymous with the widespread term MNC (Jones et al., 2015).

According to this rationale, Consensus Statement 1 was approved.

3.2 Question 2: How can CNC be measured effectively in the Italian context according to its cultural, professional, and healthcare service specificity?

Measuring CNC is a complex task and the scientific acceptability both of the measurement tools and their methodology is still under discussion (Suhonen & Scott, 2018). Different tools have been developed and validated to date using different metrics based on self-reports in which each nurse is required to indicate the phenomenon's frequency on the basis of his/her perceptions, e.g., during the last shift or week

(Kalisch & Williams, 2009; Jones, 2014; Schubert et al., 2007; Sochalski, 2004; Rochefort & Clarke, 2010). However, no gold standard has been identified yet, given that reports have indicated that the instruments available have weaknesses and strengths (Bassi et al., 2018): first, all are based upon self-reports that include subjective judgments, and thus, do not provide a true measure of the problem. However, it is challenging to collect and access actual data regarding adverse patient outcomes: therefore, surveys can be excellent forms to capture *proxy* data and determine nurses' perceptions about the quality of care they offer on a daily basis.

Based on what management scholar Peter Drucker (1998) said "You cannot manage what you don't measure" measuring CNC with the most appropriate tool among those available can have multiple benefits, as it can:

- Identify the causes and suggest appropriate interventions to prevent or minimise CNC (VanFosson et al., 2016), thus increasing patient safety and care quality (Aiken et al., 2014);

- Facilitate an open discussion about the phenomenon, discourage any punitive approach, and give voices to nurses so they can speak freely about the quality of bedside care delivered;

- Also consider neglected contexts in which both patients and nurses' vulnerability has been reported to be high and in which scarcely any data has been documented to date (e.g., nursing homes, psychiatric, home care settings), thus devoting the same attention merited compared to hospitals, where most studies have been conducted to date (Bassi et al., 2018);

- Develop the basis to undertake actions preventing all of CNC's negative consequences on patients, caregivers, nurses and healthcare institutions (e.g., Suhonen et al., 2018; Rochefort & Clarke, 2010).

Furthermore, measuring CNC can prevent any process of normalisation (Banja, 2010) such as the progressive conviction that it is 'normal' not to be able to provide all of the nursing care planned. Therefore,a comprehensive strategy is required to determine the best tool to measure the phenomenon at the national level and collect homogeneous data that allow comparisons. Moreover, the tool selected should be able to determine CNC's causes, thus functioning not as a simple measurement exercise but also as a way to inform decisions with respect to the following interventions.

CNC's occurrence could be under- or overestimated because of poor agreement regarding the standard of care to be provided, for example, on the basis of the ideal concept of what nursing care should be, the existing practices of traditional or obsolete standards of care, or interventions no longer required in some conditions (e.g., from changing the patient's position to prevent pressure ulcers at least every two hours, as in the past, to every six hours [NICE, 2014]). Therefore, it is necessary to provide a reference point for the level of nursing care that should be provided for a specific group of patients, e.g., by adopting evidence-based care plans.

Furthermore, in measuring CNC, the role of Nursing Assistants, which largely has been included in the evaluations available (e.g., Kalisch, Tschannen, Lee, & Friese, 2011), should be discussed in depth; their involvement can be important in developing a more comprehensive evaluation of the phenomenon, particularly in those contexts in which the model of care delivery is based upon the division of tasks. However, including them and using a tool inconsistent with their role can reduce the accuracy of the data collected and fail to give nurses responsibility for the nursing care process overall.

According to this rationale, Consensus Statements 2, 3, 4, and 5 were approved.

3.3. Question 3: What parameters should be considered in designing policies intended to prevent CNC in the Italian context?

More than in other contexts, limiting action to pure measurement should be considered unethical in the CNC field. Given that CNC's occurrence reflects substantially poor care, it is necessary to take immediate decisions that will protect patients. Firstly, data on CNC's occurrence should be disseminated immediately at the unit and facility levels to promote awareness, and prompt identification of causes and necessary interventions. Secondly, as soon as interventions are designed and implemented, it is necessary to disseminate findings and strategies adopted outside the facility e.g., with the reference community of citizens, as proof that the CNC issues are known and addressed. Similarly, each academic research project designed to measure CNC's occurrence should be followed by an attempt to support the unit(s)' efforts to

identify strategies to promote the quality of care and patient safety, particularly in those contexts where findings are critical.

Some studies have been published to date on the effectiveness of interventions intended to minimise CNC (e.g., Piscotty & Kalisch, 2014); however, no standardised solution is recommended, given that the phenomenon can have different causes in each unit. Therefore, it is necessary to diagnose CNC's causes at the units level by conducting an in-depth analysis of the data with the nurses involved in data collection. It should also be acknowledged that CNC is not caused by one single factor (e.g., lack of human resources); other factors, such as communication issues among nurses and other members of staff, lack of supplies, or an unexpected increase in care needs, have been documented to play a role (e.g., Kalisch et al., 2011). Furthermore, the unit's values, habits, and culture, as well as defensiveness and lack of patient consideration (Francis, 2013) can all influence CNC's occurrence, as well as the effectiveness of the changes implemented (Kalisch et al., 2009) to minimise the phenomenon. Therefore, the effectiveness of changes intended to minimise or prevent CNC's occurrence should be evaluated to determine what measures are most effective at the unit level. Cumulative experiences can increase the evidence available and help other units or healthcare systems learn and translate effective interventions in their own context.

Moreover, CNC is not exclusive to the nursing domain, because other staff members (e.g., physiotherapists, physicians) can influence or can, in turn, be influenced by it; consequently, each change in the nurses' practice can change the entire clinical care process and outcome. Therefore, it also is essential to evaluate the expected and unexpected consequences on other professional systems.

According to this rationale, Consensus Statements 6 and 7 were approved.

3.4 Moving forward: Final remarks

CNC reflects the dominant values of (a) a healthcare system with respect to what is acceptable to omit; (b) the education system with respect to what is known to have the 'lowest priority' and thus is acceptable to miss or postpone, and (c) the nursing profession with respect to what nurses 'accept' in the necessary daily compromise between the optimal care patients and families' require and what actually can be guaranteed in the context. To date, few experiences of patients and/or caregivers' involvement in measuring CNC have been documented (Kalisch, Xie, & Dabney, 2014), and more efforts are required in the future, particularly under those conditions in which patients are vulnerable and cannot negotiate their care, or express their needs or dissatisfaction with nursing care.

Moreover, as inspired by the International Code of Ethics (ICN, 2012, article 3) according to which "The nurse assumes the major role in determining and implementing acceptable standards of clinical nursing practice", professional boards at different levels should support nurses in addressing CNC issues, both as individuals and as a professional community. Furthermore, specific actions at the educational and research levels must be developed to prepare both clinical nurses and leaders to address this emerging phenomenon, as well as undertake innovative approaches to move from measuring its prevalence to continuing measures (e.g., electronic) that embrace all care processes.

According to this rationale, Consensus Statement 8 was approved.

4. DISCUSSION

This consensus process exercise was intended to develop the basis for concrete policy and actions development (Benton, Cusack, Jabbour, & Penney, 2017) and was conducted in a field in which no previous similar experiences have been documented to date. Its findings were developed over more than one year of engagement by analysing the literature and consulting stakeholders, including patients' representatives, in accordance with the methods of consensus available in the literature (James & Warren-Forward, 2015).

To facilitate the translation of the evidence into practical implications, we conducted a consensus process: in the first step we had to look for another term rather than MNC to adapt its meaning to the specific cultural and social Italian context. According to the debate, the term CNC was considered more culturally and socially acceptable in the context as a synonym of all existing terms (e.g., MNC, Rationing, Tasks Left Undone) which have been found to have a negative meaning. On one hand, the process of translating and adapting the term used into different languages, can increase conceptual uncertainty; on the other hand, it can increase the likelihood of its dissemination. However, according to the findings, CNC is a synonym of MNC culturally acceptable in the Italian context.

By translating CNC's implications cooperatively in the actual context of Italian nurses, we tried to equip nurses at different levels with the competence to be engaged locally (Benton et al., 2017), thus allowing them to shape, rather than be controlled by, policies (Porter-O'Grady, 2011). There has been a long debate with respect to nurses' poor engagement in policy development (Turale, 2017); as Porter-O'Grady (2011) commented, nurse leaders and scholars have expressed a litany of comments time and time again when addressing the critical issue of the way nurses influence policy making and the political agenda. Moreover, together with the formal approval of the Consensus Statements, the process itself may have increased the nurse participants' power and their competence with respect to ways to address this phenomenon.

A large part of the Consensus Statements approved focused upon actions rather than measurement, confirming that this field should devote more attention to interventions and test their effectiveness in preventing or minimizing MNC. Many nurse researchers have recognised recently that the MNC phenomenon is an urgent matter; however, the tendency up until now seems to be oriented to continuing to measure the phenomenon rather than implementing actions to minimise or prevent it (Fitzpatrick, 2018). The famous Francis Report (2013) has already established that "… the purpose of identifying where individuals have fallen below relevant standards … becomes a futile exercise to undertake" (Francis, 2013, Executive Summary p. 35). The Consensus Statements developed can guide decision-makers in their efforts to develop policies and actions addressing the occurrence of missed care in the

Italian context. However, in addition to these recommendations, it is necessary to develop more appropriate instruments and measures to obtain robust evidence of the effectiveness of the interventions implemented (Suhonen & Scott, 2018).

The NG removed two Consensus Statements in the final stage of the process. The first referred to academic hospitals where students' presence can increase the likelihood of CNC because of the time that clinical nurses must devote to them; however, nursing students also can prevent CNC's occurrence through their contribution in delivering care as members of the team. Moreover, no consensus was achieved with respect to the need to measure CNC only in contexts in which the nurse-to-patient ratio is below the compulsory ratios: conflicting results have been documented in some countries where a lack of resources paradoxically has paralleled a decrease in the occurrence of MNC according to nurses' reports, given their perception that they work with increased intensity and provide all care required (Palese et al., 2015). The elements mentioned above require further investigation and analysis.

5. LIMITATIONS

We adopted the Consensus Development Method because of its ability to integrate scientific knowledge, values and beliefs, expertise, and consumer experiences (Halcomb et al., 2008). In the first stage of the process, a few stakeholders have been involved in the NG as experts in the MNC field and this might have affected the quality of the process and consequently the findings. However, despite the wide invitation to participate extended to the national level to ensure a good geographical distribution, no demographic data relating to the participants was collected. Moreover, in this first methodological exercise, we involved only one large association that represents the families of the most vulnerable patients, such as those suffering from dementia. Accordingly, better inclusion processes in further experiences are strongly suggested. In the final conference, we adopted the explicit method of voting to approve the consensus statements by a show of hands after a reflexive and interactive process (Halcomb et al., 2008). The limited time (two days) available also may have constrained the attendees' full and active participation. Furthermore, Consensus Statements' strengths were not weighted.

Throughout the process, we used the overarching term, MNC, according to the interchangeable use of the different concepts developed in this field, including Rationed Nursing Care and Tasks Left Undone (Jones et al., 2015). However, the validity of the consensus development process undertaken, as well as of the findings that emerged for other concepts, such as that of 'Failure to Maintain' (Bail & Grealish, 2016), and 'Care left undone' (Ball et al., 2014; Jones et al., 2015) should be verified.

Finally, although all nurses' scope of practice has theoretical and practical similarities, differences across cultures attributable to policy contexts, healthcare settings, and competences and roles developed through education, have been found to differentiate the nursing profession across countries (Benton, Al Maaitah, & Gharaibeh, 2016). Therefore, scrutiny of the recommendations' external validity is recommended before their implementation in other contexts.

6. IMPLICATIONS FOR NURSING MANAGEMENT

The recommendations that emerged suggest adopting a comprehensive reference framework for the nurse managers at the national level that begins by measuring the phenomenon, then identifying the interventions required at the local level, followed by implementing those changes, and ending with a post-implementation measure of MNC's occurrence. These core passages confirm that poor care requires a systematic approach (Norman & Griffiths, 2019) in which the nurse managers play a pivotal role. Moreover, by informing citizens at each stage of the process, their full involvement can re-establish the social contract between nurses, patients, and/or their representatives (Richards & Borglin, 2019). Patients and relatives also should be involved in measuring missed bedside care, thus complementing the nurses' measures that can provide average values over all groups of patients receiving care. Furthermore, given its relevant ethical implications, nurse leaders involved in Nursing Professional Boards are called to undertake actions through appropriate codes of ethics to support nurses in the care they deliver daily by comparison to the ideal care required.

7. CONCLUSIONS

We developed a consensus process firstly to incorporate the MNC phenomenon into Italian culture by agreeing on the term Compromised Nursing Care that best reflects MNC's meaning and allowed an open discussion of the phenomenon both within and outside the profession. A total of eight Consensus Statements emerged, organised in a series of sub-statements that reflect a systematic approach that begins with measuring CNC and finishes by measuring its occurrence again after the concrete actions developed have been implemented. The set of statements that emerged can guide decision-makers as they develop concrete policies and actions that enhance the quality of care and patients' safety by minimising or preventing the occurrence of missed nursing care in the Italian context.

Ethical Approval

Ethical approval was not required for this paper.

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Table 1. Consensus Statements Approved

Consensus Statement 1: Rendering the Missed Nursing Care Concept Culturally Acceptable

1. Because of the need to discuss the phenomenon openly and positively within and outside the profession, the concept that reflects MNC in the Italian context best is that of Compromised Nursing Care (CNC). Etymologically, the concept of *compromise* in Italian ('*compromesso*') means to give up some aspects of what has been promised (as planned, needed, agreed) to manage a controversy (Vocabolario Treccani, 2018) as the contrast between what would be necessary for the patients/caregivers and what nurses can actually provide. CNC should be considered in the broader concept of patient safety and nursing care quality and a synonymous of the concept of MNC.

Consensus Statement 2: Measuring CNC as a Strategy to Increase Patient Safety

2. It is recommended to measure CNC periodically as a key strategy to improve patient safety and the quality of nursing care. The measurement of CNC's occurrence should be a strategy to:

    2.1 Increase patient safety in those settings where the culture of critical evaluation of adverse outcomes or near misses is not implemented widely or where systems that prevent adverse events are not established fully. Measuring CNC can be a proxy indicator of patient safety because it informs processes implicated in the occurrence of adverse events before these events become visible and appreciable, e.g., measuring compromises in nursing surveillance or mobilisation as a proxy indicator of falls or pressure injuries;

    2.2 Increase timely awareness of issues in nurses' performances at different levels (e.g., unit and clinical facility, whether hospital or community setting) before adverse outcomes occur;

    2.3 Ensure nurses the opportunity to express their perceptions of CNC and discuss openly: (1) its occurrence in the unit; (2) similarities or differences in their perceptions; (3) CNC's causes and the interventions required to prevent/minimise it, and (4) ethical implications;

    2.4 Promote supportive and ethical work environments where CNC issues are discussed openly: in these environments, nurses' moral distress, professional dissatisfaction and turnover, as well as the growing conviction that it is normal not to provide the nursing care planned can be prevented, and

    2.5 Include those contexts in which both patients and nurses' vulnerability have been reported to be high and in which few data has been documented to date (for example: nursing homes, psychiatric units, home care).

Consensus Statement 3: Selecting an Appropriate CNC Measurement Instrument

3. In designing and conducting periodic measurements of CNC, the instrument used, its goals, metrics, and methods of compilation, should be appropriate to nurses and healthcare systems' current practices. Therefore, it is recommended to adopt a validated tool that:

    3.1 Reflects the entire complexity of nurses' scope of practice and role as agreed at the current professional and academic levels-----, thus avoiding instruments that include only a set of tasks that suggest the existence of a strictly limited set of nurses' duties;

    3.2 Ensures a comprehensive estimation of CNC, not just one that ticks boxes indicating which tasks have been 'done' or 'not,' but rather also includes intangible elements, such as critical thinking, decision making, surveillance of patient progress, or other relevant nursing interventions (for example: education, emotional support) that reflect nursing care's core elements;

    3.3 Avoids overlap with existing measurement systems, particularly in the context of patient safety at the local, regional, or national levels to prevent redundant measures (for example: with surveys that evaluate handwashing or compliance with preoperative check lists);

    3.4 Ensures consistency with the decision-making support systems available: for example, in hospitals that work on the basis of bundles of care, it may be difficult for nurses to complete a measurement tool that does not reflect the same principles; at the same time, individual items in a bundle included in a tool may not reflect the entire bundle's actual level of threat and the converse depending upon the action compromised (for example: not respecting the time to administer appropriate antibiotic prophylaxis before surgical incision compromises the entire bundle);

    3.5 Is appropriate for the group of patients cared for, and consistent with the evidence available in the field, including the most relevant/essential aspects of nursing care in a specific context (for example: in a nursing home where disturbed behaviours in older individuals with dementia are managed vs. performing early mobilisation in the surgical context);

    3.6 Uses the 'last shift' as the time reference when nurses are asked to report CNC to avoid/reduce recall

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bias;

3.7 Uses appropriate metrics in which: (1) ordinal measures are preferred (from always compromised to never) by avoiding the 5-point Likert scale to prevent the tendency to report central measures, and (2) also including 'not applicable' for those interventions inappropriate to the context;

3.8 Includes as well the evaluation of the extent of CNC's perceived causes to guide decisions on subsequent interventions (for example: multidisciplinary collaboration issues, sudden intensification of work processes, lack of technological or human resources);

3.9 Considers an instrument consistent with the practice of Nursing Aides when they are involved in the detection of CNC, and

3.10 Provides a frequency measure consistent with the clinical context and its peculiarities: an annual evaluation may be sufficient in a stable environment where patients' length of stay is long, while more frequent measures are recommended in those units that face organisational changes and/or have high patient turnover.

Consensus Statement 4: Optimising CNC Measurement

4. In conducting the CNC measurement, the full participation of nurses working in diverse clinical settings (hospital, community, residential and/or rural hospitals) should be encouraged, informing them of its relevance, uses, and data confidentiality, and thus discouraging any punitive approach. Moreover, to ensure accurate measures, it is recommended to:

4.1 Improve technology to allow data to be reported easily, thus avoiding paper-based methods and preventing additional CNC, as surveys take time that otherwise could be spent in direct patient care;

4.2 Ensure appropriate training for nurses involved in the surveys to share CNC's significance and that of the measures used;

4.3 Ensure a common basis of reference with respect to what nursing care should be in a specific context by developing evidence-based nursing care plans, and

4.4 Avoid single surveys by implementing a measurement system able to monitor CNC continuously, thus increasing progressively nurses' confidence in understanding CNC, their awareness and the usefulness of the data collection in detecting trends and discovering the effectiveness of the interventions implemented to prevent CNC.

Consensus Statement 5: Promoting CNC Data Analysis

5. Data collected should be analysed and returned at the appropriate level and be able to ensure full recognition of CNC's occurrence and its causes by those staff involved in data collection by avoiding macro aggregates that prevent an in-depth understanding of the phenomenon. Therefore, given that each CNC measurement should be considered a substantial source of learning, it is recommended to:

5.1 Disseminate CNC measures at least (1) at the unit level to the nurses who produced these measures; (2) to each unit's multidisciplinary team, given that CNC can affect multidisciplinary outcomes, and (3) to nursing and non-nursing managerial staff, and

5.2 Benchmark the CNC measures by identifying averages in a given context, trends across and within similar units, and also extreme positive or negative cases for their lower or higher occurrence of CNC to facilitate improvements.

Consensus Statement 6: Designing and Implementing Interventions to Prevent and/or Minimise CNC

6. The intervention(s)' design and implementation should carefully consider the specificity of the context, culture, habits, and values associated with the CNC causes diagnosed to implement appropriate change strategies together with the interventions' appropriate implementation. Therefore, it is recommended to:

6.1 Not leave clinical nurses and nurse managers at the unit level alone, but support them in identifying the best interventions to limit CNC's occurrence;

6.2 Adopt a proactive approach by involving nursing staff: nurses and nurse managers all play important roles in recognising CNC's causes and in initiating appropriate interventions. Therefore, it is necessary to avoid prescriptive policies or top-down impositions that may provoke increased, rather than reduced CNC (for example: imposing a regular round at the bedside that can compromise other nursing interventions) or erecting barriers that affect nursing staff adversely;

6.3 Appraise nurses critically if the data on CNC occurrence suggest the need for urgent/immediate or planned interventions, as CNC can threaten the ethical principles of clinical practice and the safety of patients seriously;

6.4 Identify interventions based on the situation if relevant to the causes identified in the specific context

and avoid standardised solutions across settings;

6.5 Consider different organisational levels by targeting structure (e.g., human resources) and processes (e.g., the number of non-nursing activities nurses perform; lack of skills in priority setting) according to CNC's estimated causes;

6.6 Focus on the causes that nurses and nurse managers can modify, and search for multidisciplinary alliances for those causes that the nursing profession cannot control completely at its different levels;

6.7 Reflect CNC's multidimensionality by designing complex interventions that include different interacting components, thus avoiding simple or linear approaches, and

6.8 Identify appropriate indicators for immediate, short-term, and intermediate and long-term outcome evaluations, according to the estimated CNC causes.

Consensus Statement 7: Assessing and Disseminating Findings on Interventions' Effectiveness

7. The effectiveness of interventions designed and implemented should be evaluated by reassessing CNC with the same tool used during baseline after an appropriate interval depending upon the nature of the interventions implemented. In evaluating the interventions' effectiveness, it is recommended to:

7.1 Document both positive and negatives effects, such as unwanted/unanticipated consequences on other processes or healthcare professions: CNC is not exclusive to the nursing domain because it can influence or can, in turn, be influenced by, those who work with nurses (for example: physicians). Consequently, each change in the nurses' practice can change the entire clinical care process and outcomes.

7.2 Provide opportunities to discuss the outcomes achieved and share best practices when effective: interventions designed to minimise CNC at the micro level (single unit) can be extended to the meso (hospital, district) and policy levels, and

7.3 Disseminate findings within the profession and health systems, and outside the profession in the community of citizens, individually or in associations, by ensuring that the reports are simple to understand.

Consensus Statement 8: Moving Forward: Final Remarks

8. CNC threatens patient safety and nurses have a responsibility to prevent it. Therefore, the entire nursing and healthcare system is called upon to measure CNC, identify its causes, and minimise its occurrence by implementing appropriate interventions and measuring them continuously. In taking these actions, it also is recommended to:

8.1 Involve patients in the evaluation processes because their point of view can augment/complete the nurses' perceptions;

8.2 Involve family members, caregivers, or associations as a proxy of the patients' perceptions, particularly when they cannot express their point of view (e.g., because of cognitive decline) and therefore are more vulnerable because they cannot negotiate or report their dissatisfaction and/or complain that they have not received the nursing care required;

8.3 Identify professional policies with the Regional and the National Nursing Boards with respect to CNC's ethical and deontological implications: Specific indications in the code of ethics are required that support the individual nurse and the entire community of nurses to guide decisions under conditions that expose nurses and patients to a high risk of unacceptable levels of nursing care;

8.4 Develop a professional consensus on what should be considered acceptable CNC (e.g., postponing nursing care from the morning to the afternoon without any effect on the patient) and what should be considered unacceptable according to the ethical principles of nursing care and patient safety;

8.5 Establish a strong partnership with those nurses responsible for undergraduate, advanced, and continuous nursing education to:

8.5.1 Introduce CNC in the undergraduate nursing programme, and its preventive strategies and measures; create occasions in the clinical learning environment (e.g., debriefings session) to discuss and reflect freely with students about CNC, its causes, and prevention;

8.5.2 Prepare future nursing generations to make effective decisions in times of scarce resources (e.g., priority setting skills), to recognise and minimise CNC early, and

8.5.3 Incorporate more advanced education on the phenomenon in the Master's Science Programmes in which nurses aspire to acquire effective leadership to guide the future.

8.6 Establish strong partnerships with academics, research centres, and PhD programmes at the national and international levels to:

8.6.1 Simplify the CNC measurement process by designing and testing electronic evidence-based

	plans of care in which nurses can report the gap between the nursing care planned and actually delivered at the patient's level to allow a continuous evaluation of CNC rather than a measurement based upon prevalence data;
8.6.2	Transition from self-reported CNC measures to objective measures of objective indicators, and
8.6.3	Move from measuring CNC alone to developing instruments able to evaluate the entire process of multidisciplinary care and its failures.

Note. CNC: Compromised Nursing Care, MNC: Missed Nursing Care

Figure 1. The Consensus Method Development: Summary of the steps, the phases and of the outputs

Step	Phases, time, participants	Outputs
Step 1: Identification	*1. Summarizing the knowledge available in the field and translating into the Italian language* December 2017 Participants = 3	Regarding three main questions (1) What are the concepts used in the field of MNC? What theoretical framework do they reflect? (2) What instruments have been validated to date to measure MNC? (3) What interventions have been proven to prevent MNC? a summary of the evidence (Bassi et al., 2018) was published in Italian language.
	↓	↓
	2. Identifying MNC peculiarities in the Italian context September 2016 - 2018 Participant = 1	An active participation in the RANCARE COST Action[†] meetings was ensured Emerged notes and insights were recorded.
	↓	↓
	3. Identifying experts, summarizing evidence and experiences in the field February 2018 - May 2018 Participants = NG members	Three main consensus development process questions were emerged, discussed and agreed: (1) Which term that best reflects the meaning of MNC should be recommended to be used in the Italian language according to its cultural, professional and health care service context? (2) How MNC could be effectively measured in the Italian context according to its cultural, professional and health care service specificity? (3) What parameters should be considered in designing policies aimed at preventing MNC in the Italian context? A summary of the evidence available, integrated with NG members' experiences in the field and with the recorded notes/insights (see phase 2) was prepared. A PowerPoint presentation on each question was developed and shared among the NG members.
	↓	↓
Step 2: Discussion and Synthesis	*4. Designing and running the Consensus Conference* February 2018 - May 2018 Participants = 218	A brief presentation on questions was given by NG members: (1) the first day of the Conference (28 May) was held at the University of Udine (Italy) aimed at developing the first two questions (see above); (2) the second day of the Conference (29 May) was held at the University of Trieste (Italy), aimed at developing the third question (see above) After an open discussion with the attendees (=218), a set of Consensus Statements (=10) articulated in sub-statements emerged; these were read aloud by the NG leader and voted by participants by showing their hands.
	↓	↓
	5. Consulting patient with dementia representatives as stakeholders July – October 2018[††] Participants = NG leader and the President of the Association	The decision to involve patients with dementia representatives was undertaken by the NG members because (1) these patients are the most vulnerable regarding MNC given their inability to express their care needs, or report missed interventions; and (2) improving their care has been established as a policy priority in several countries (e.g., Handley, Bunn, & Goodman, 2018). The Association was contacted through the President and then a draft including the Consensus Statements was sent. In a meeting with the President the Statements were discussed and agreed upon. One statement was enriched according to the request of the Association regarding the need to involve family members, caregivers or associations as a proxy of patients' perceptions when they are vulnerable, unable to express their needs or report their dissatisfaction with nursing care, e.g., due to cognitive decline or dementia.
	↓	↓
	6. Refining the Consensus Statements and final approval July – November 2018 Participants = NG members	Consensus Statements and sub-statements were revised in their wording aimed at ensuring homogeneity and clarity. Then, two statements were removed as they had achieved an agreement of <0.70 by the NG members evaluating the content validity. Specifically, there were two statements removed regarding (1) academic hospitals, where MNC can affect the quality of the clinical teaching or can be caused by the time devoted to students; and (2) the need to measure MNC only in those contexts where the nurse-to-patient ratio is below the mandator ratio as defined by regional policies. Therefore, eight Consensus Statements were finally approved by the NG.

Note: MNC, Missed Nursing Care; NG, Nominal Group.

[†]The RANCARE COST Action project is aimed at facilitating the discussion about MNC by a cross-national comparative approach with implications for practice and professional development by advancing collaboration and networking, and by integrating different disciplines including nursing, ethics and moral philosophy, health care studies in general, economics and social policy. Since its establishment in September 2016, an Italian member has ensured an active participation in the meetings and recorded the emerged notes/insights.

[††]Regional Board of Association of Families of individuals suffering from dementia (Coordinamento Associazioni Alzheimer, Friuli Venezia Giulia, Italy)