Nurses' Perspectives on Rationing of Care and Automated Thinking

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ABSTRACT

The terms care rationing and missed care are often used within the literature to describe nursing practice that falls short of delivering person-centered care. Nurses face various challenges and constraints in care delivery, which often lead to rationing care or missed care. In this discussion paper, nurses' experiences with care rationing, missed nursing care and automatic thinking and other possible solutions are explored.

Key Words: ageism, older persons, self-perceptions

Fiscal constraints within healthcare can lead to changes in nursing team composition and processes of care (Jacob et al., 2015). Hospitals under financial constraints contributes to nurses struggling to maintain quality and safe patient care, and are associated with unfavorable outcomes for patients, nurses, and healthcare organizations (Akinleye et al., 2019; Aiken et al., 2018; Uchnanaowicz et al., 2024; Witczak et al., 2021). Research has demonstrated a significant association between higher staffing of professional nurses (Registered Nurses- RN) and lower morbidity (Aiken et al., 2018). When there are less RNs in the nursing team and they are working in often chaotic hospital environments, RNs must make choices about which patients' care to prioritize and which patients to delegate to a member of the healthcare team, such as a care aide, who has less formal education. Nurses make these choices in the moment as they are trying to survive their shift. In these high pressured, time sensitive situations nurses may rely on fast or automatic thinking rather than critically thinking about each patients' care needs, which may lead to care rationing or missed nursing care. Nurses report that being unable to give adequate patient care is frustrating and results in low job satisfaction (Abelhadi et al., 2020; Friganovic et al., 2019; Papastavrou et al., 2014). When nursing professionals experience

insufficient resources, stress and constant changes, they may feel frustrated, low self-esteem, feelings of incompetence, low job satisfaction and avoid contact with the patients (Jarosz et al., 2022). Nurses may ration care by omitting or shortening certain nursing care activities, which does not support person-centered care (Jarosz et al., 2022). Person-centred care has been defined as delivering care in ways that includes the persons' beliefs and values, engaging authentically, sharing decision-making and providing holistic care (McCormick & McCane, 2021). In this discussion paper nurses' experiences with care rationing, missed nursing care and automatic thinking and offer possible solutions are explored.

Background

The terms care rationing and missed care are often used interchangeably in nursing practice literature. Care rationing has been defined as withholding essential nursing tasks or tasks are partially, totally omitted, or delayed due to time constraints or a shortage of staff and resources (Friganovic et al., 2019; Papastavrou et al., 2014; Scott et al, 2019). *Implicit rationing of care* is defined as failure or refusal to provide necessary nursing care to patients due to a lack of resources (Zeleníková et al., 2023). Mandal et al. (2020), systematic review of care rationing asserts that although nurses must consider physical, mental, psychological and spiritual aspect of patients while delivering care, there are situations when nurses must prioritize one aspect or one patient of another leading to care rationing. Other scholars have suggested that staffing levels, patient turnover and complexity of care can lead to care rationing (Scott et al., 2019). Moreover, care rationing is correlated with poor patient care, decreased patient and nurse satisfaction, higher adverse events, longer stays, readmissions, has serious implications on patient's safety and is a threat to the professional's health (Mandal et al., 2020). After completing a systematic review of the literature, Chiappinotto et al. (2022) reports that missed nursing care is the omission or delays in care due to increased patient to nurse ratio, unavailability of resources, team norms, decision-making, professional relationships, shortage of staff, environment, and management. Missed care comes under the category of error of omission Patient Safety Network [PS NET], (2019). Scholars suggest that *Unfinished nursing care* is due to scarcity of time often due to nurses' clinical priority setting that results in care left undone (Chiappinotto et al., 2022)

Nurses decision-making processes when they have little time may provide an understanding about contexts that result in rationing care/missed nursing care. It is estimated to take around eleven to sixteen seconds to analyze a novel situation and come to a conclusion (Newell, 1990). When immediate action is required 16 seconds can made a significant difference in a patient outcome. Yet, Cisneros (2009) suggests that nurses rely upon externally developed protocols and internally developed mental scripts based on similar clinical situations. Externally developed protocols are a set of standards that are developed to enhance the safety of people and reduce the chances of error. However, it is essential that critically reflective thinking is used to interpret the new situation in the context of protocols. When a novice is faced with a new situation, they try to apply knowledge they have to the situation, whereas an expert remembers similar situations they have experienced and applies them to their current situation (Cisneros, 2009).

Scholars who have examined how people in general make decisions suggest that we engage in both fast and slow thinking (or critically reflective thinking), often defaulting to fast thinking as it is less cognitively demanding (Kahneman et al., 2011). Kahneman et al. (2011) discusses two systems of thinking in human reasoning that is system 1 (fast thinking) and system 2 (slow critically reflective thinking). System 1 is considered quick, instinctive, reactive, and holistic. It uses heuristic reasoning without the mental effort of reflective thinking. In contrast, system 2 is considered as reflective, analytical, deliberative, and procedural. System 2 is usually associated with reflective problem-solving and critical thinking. But, in the decision-making process, system 2 also uses a heuristic approach. Both of these two systems of thinking are needed. Similar to Kahneman et al. (2011) description of fast and slow thinking, Abdelhadi et al. (2020) asserts that nurses distinguish between two types of thought processes and automated thinking is used in routine situations; whereas effortful thinking is used in more novel situations.

Edel (2011) refers to fast thinking as automatic thinking, comparing it to routines such as driving a car. When relying on fast or automatic thinking, there is a risk of overestimating or underestimating a situation. It is not clear how often automatic reasoning impact nurses' clinical reasoning. Although novice nurses are more likely to misidentify a clinical situation, an expert does not assure, flawless clinical decisions. Experts are also likely to misidentify the clinical situation or pay less attention to the differences between the new situation and the previous one. (Cisneros, 2009). Abdelhadi et al. (2020) suggests that in routine situations nurses are more likely to engage in automatic thinking and make decisions about whether to omit or delay care based on their past experiences. Patients who nurses consider non-urgent may be overlooked in this automatic thinking. Effortful thinking which is needed to differentiate the differences between previous situations and the current one is generally reserved for situations that appear more novel. This is similar to Kahneman et al (2011) slow thinking.

Nurses' perspectives on rationing of care

Patient safety resides under the umbrella of quality care. Quality nursing care means meeting patients' needs through advocacy, empathy, fulfilment of patients' needs, good interpersonal relationships and teamwork (Nyelisani et al., 2023). Rationing of nursing care is a significant threat to patient safety and quality of care resulting in unfavorable consequences for patients, nurses, and healthcare organizations (Papastavrou et al., 2014; Uchnanowicz et al., 2024; Witczak et al., 2021). It is also associated with patients' poor attitudes towards care, decreased patient trust and increased patient mortality, medication errors, patient falls, pressure ulcers, and nosocomial infections (Ausserhofer et al., 2013; Ball et al., 2018; Kalisch et al., 2009; Scott et al., 2019). Theoretical models assert that nurses' automated thinking is behind care rationing or missed nursing care (Schubert et al., 2007). However, nurses' perspectives on care rationing and automated thinking suggest several contributing factors at the organizational, unit and patient's level (Chiappinotto & Palese, 2022).

How nurses can default to fast or automatic thinking

People make decisions as individuals within the social system to which they belong (Hare, 2013). In situations, where nurses have gained much experience, decisions, and care rationing may be based on team norms and priority setting of how care is enacted on a particular unit (Kalisch et al., 2009). Team norms are what is expected from the members of the team, are usually implicit and if the norms are not followed nurse risk social isolation by the team (Homans, 2017). Moreover, nurses assess their patient's needs and conditions within an ever changing context, thus, their assessments are dynamic and often need to be made quickly (Abdelhadi et al., 2020; Friganovic et al., 2019). Nurses believe that emergency situations triggers their awareness and judicious judgment rather than dealing with the same procedures daily (Abdelhadi et al., 2020). However, nurses report feeling oppressed by organizational policies and the need to do administrative work rather than focussing on patients' needs, which results in care rationing of care (Chiappinotto et al., 2022; Friganovic et al., 2019). Some nurses report the presence of a supportive leader prevents care rationing; other nurses feel criticized when leaders ask them questions, which increases work pressure (Abdelhadi et al., 2020). Other scholars report that inadequate leadership can have an impact on nurse- patient relationships, which can lead to care rationing (Chiappinotto & Palese, 2022). Newly qualified graduates, lack of transition to practice programs and the lack of orientation programs can also lead to care rationing (Chiappinotto & Palese, 2022)

In Chiappinotto and Palese (2022) qualitative study, nurses identified several contributing factors behind unfinished nursing care. These factors included the layout of the care environment, such as long distances between patients rooms and the nursing station, high numbers of patients in a room with their belongings, high volume of interruptions by telephone calls, or colleagues, shortage of nursing staff and healthcare assistants, medical equipment in the hallway, poor communication among the care team and unpredictable workloads due to admissions or an unstable patient (Chiappinotto & Palese, 2022). Moreover, when material resources were not available, calling for them results in postponing or omitting aspects of care (Chiappinotto & Palese, 2022). A shortage of nursing staff or healthcare assistants requires nurses to do more with less of them, leading to care rationing. Furthermore, when nurses have challenges in contacting physicians during night shifts or weekends, more time is spent trying to track down the physician and patient care at the bedside suffers. Team norms about leaving care to talk to a physician, or attend to a policy related to locked medications, and less staffing of nursing and other professionals on weekends and nights all lead to care rationing (Chiappinotto & Palese, 2022).

Friganovic et al. (2019) reported that 67% of nurses find it difficult to meet nursing care demands due to lack of human and material resources and communication challenges. Other challenges nurses face that are unstable patients which require nurses attention to their medical needs and leads to de-prioritizing activities of daily living or other patients who are clinically stable (Abdelhadi et al., 2020; Chiappinotto et al., 2022). Moreover, cognitively impaired patients can be more time consuming leaving less time to provide care to others. (Chiappinotto &

Palese, 2022). Furthermore, sometimes patients or families who are perceived by nurses as annoying or irritating, due to their demands and supervision of nursing activities, can influence nurses decision-making about care rationing (Abdelhadi et al., 2020). On the other hand, some relatives help their loved one with care decreasing nurses work (Abdelhadi et al., 2020).

Professional Role Conflict

In our argument, we have discussed various factors which contributes towards care rationing. However, nurses perceive the major contributing factor is the professional practice environment, which highly impacts nurses' decision-making and results in professional role conflict. Professional role conflict is the inconsistency between nurses' desired actions and the actual implemented actions, and these conflicts arise due to the organizational policies, expectations, time constraints and limited power to negotiate. These hierarchical policies and power limits the opportunity of nurses to give quality nursing care and to act according to their set individualized nursing care plans (Papastavrou et al., 2014). Their decision-making may also be imposed by a hierarchical model which devalues the fundamental aspects of patients' care and focuses more on the good business aspects for the hospital (Aiken et al., 2018). When unable to meet the goal, nurses experience feelings of dissatisfaction, negative emotions, an ethical burden and moral distress, which can last for a long time (Friganovic et al., 2019; Papastavrou et al., 2014). For example, when nurses are asked to leave the patient in the middle of care because a physician cannot wait, they may experience frustration, low job satisfaction and moral distress and choose to leave their job. In addition, nurses may have no power to negotiate and feel forced to make prioritization according to the norm set by the unit, team and the management. According to Papastavrou et al. (2014), from the managerial point of view, prioritization is to be done according to the severity of the patient's condition and the urgency of the patient's needs. This can lead to nurses following minimal standards of care rather than aiming at excellent practice. As the nurses gain higher positions in nursing hierarchy, they get the additional responsibilities of satisfying the stakeholders, doctors, patients and hospital administrators which becomes contributes to care rationing (Papastavrou et al., 2014). Similarly, Friganovic et al. (2019) in their systematic review pointed to nurses experiences of burnout due to their experiences of being constantly overloaded. Li et al. (2023) noted in their phenomenological study of nurse's experiences with care rationing the importance of nurse's having access to supportive managers, ongoing professional education and as well as feeling supported by the organization.

A Path Forward

Nurses often prioritize their work according to the principles set by the medical model such as prioritizing doctors' rounds, diagnostic procedures, and medicine administration. This can undermine other values of professional care, person-centered care (McCormick & McCance, 2021) and create ethical challenges. It is therefore important that system level changes be explored to support nurses ability to provide person-centered care (Papastavrou et al., 2014; Scott et al., 2019). Managers need to ensure that nurses have the time to engage in critically reflective thinking about

their patients care, rather than trying to spread themselves over too much work, which leads to quick or automatic thinking and can lead to care rationing and missed care. Nurses can engage in journaling to strengthen their reflective critical thinking. It is essential for nurses to develop and strengthen their critical thinking skills to feel confident in knowledge and practice and to deliver quality and effective care to patients (Daly, 1998). Critical thinking and reflective problem solving are two skills that are required in making clinical judgments and is considered as a standard of practice (Cisneros, 2009). Novice staff and trainees should be given time to think through posing cases that are complex and encourage them to learn strategies to prevent care rationing and missed care (Cisneros, 2009).

Conclusion

Care rationing is a complex issue which has adverse outcomes for patient care and results in nurse burnout and turnover. The nursing profession needs to openly discuss care rationing and work with leaders in ensuring they have the resources needed to provide person-centered care. Therefore, it is incredibly important to take measures to standardize the nurses' scope of work and also provide nurses with essential resources that can result in a reduction of care rationing. An open discussion among nurses and their managers about fast or automatic thinking that contributes to care rationing in an effort to manage what they perceive as unwieldy workloads is needed. A new model of care needs to be developed to outline manageable workloads that provide nurses with the time to reflect and think critically about the patients in their care is essential.

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