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1. Have made substantial contributions to conception and design, or acquisition of literature, or analysis and interpretation of literature (CO'D; T.A);
2. Been involved in drafting the manuscript or revising it critically for important intellectual content (CO'D; T.A);

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3. Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content (CO'D; T.A);
4. Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved (CO'D; T.A).

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Article type : Special Issue Paper

Title: Care Accommodation in the acute care setting: missed care or not?

Abstract

Aim: To explain how nurses care for patients with stroke in the acute setting, when working within constraints.

Background: Internationally, healthcare environments are experiencing constraints such as reduced staffing levels, lack of time and resources. In such circumstances patient care is often of poorer quality or missed entirely.

Method(s): Classic grounded theory methodology was used to explain how care is provided within the acute care setting for patients following stroke. Data were collected using unstructured interviews with 32 nurses.

Results: Care accommodation a typology of caring was generated consisting of; functional caring, assisted self-caring and ideal caring. Depending on the degree of constraint, nurses consciously or subconsciously prioritise care, potentially leading to missed care.

Conclusion(s): Care accommodation elucidates what happens to care delivery with limited resources. Missed care may result on engaging with care accommodation, a factor nurses and managers need to consider in care delivery.

Implications for Nursing Management: Care accommodation provides new insight and understanding for management of the daily challenges nurses face thus, informing nursing management supports nurses, advocating at higher levels for resources to provide necessary environments and strategies to reduce missed care.

Keywords

Missed care, constraints, acute setting, stroke, grounded theory

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Introduction

Globally, there is a continued focus on delivering safe, quality, patient centred care to improve patient outcomes (Kirwan et al., 2019; World Health Organisation, 2017). However, internationally healthcare services are challenged in delivering quality care in busy, demanding environments, often lacking resources (Jangland et al., 2018). Constraints in today's healthcare environments are many and varied from reduced staffing levels and skill mix, reduced budgets and reduced resources to less time available to care (Clarke and Holt, 2014; Winsett et al., 2016) all of which influence care provision. Under resourced environments influence the occurrence of missed care (Ball et al., 2018). Missed care features predominantly in the current discourse on care provision where nurses often omit or ration care, leading to poorer quality patient care and patient experiences (Griffiths et al., 2018). The context of care is essential to support delivery of quality care for all patients especially those following stroke cared for in the acute care setting (Clarke and Holt, 2014; Seneviratne et al., 2009) which is the context of this paper.

Background

In line with classic grounded theory a narrative review was undertaken prior to theory generation. This narrative review afforded a broad overview and synthesis of a wide range of published literature on this area (Ferrari, 2015). The global incidence of stroke is increasing. It is the second leading cause of death in the developed world and a leading cause of acquired major physical disability (Kings College London, 2017). Internationally, designated stroke units are identified as best practice however, despite best evidence, only 30% of patients with stroke are cared for in designated stroke units across Europe (Kings College London, 2017).

Kalisch et al (2009) first coined missed care as any facet of patient care not attended to or delayed. Good stroke care involves careful monitoring of blood pressure, temperature, oxygenation and blood glucose to avoid complications (Cross, 2008). O'Connor (1993) identified the role of the nurse in stroke care in areas such as bathing, toileting, dressing, moving and positioning. These caring roles are frequently reported as missed care incidents (Blackman et al., 2018; Kalisch et al., 2011). Nurses are aware of what optimum stroke care entails however, often provide a reduced level of care influenced by the presence of constraints (Clarke and Holt, 2014; Seneviratne et al., 2009).

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Patients should receive care according to their need or acuity however, hectic acute care environments are a daily reality, where nurses must prioritise and/or rationalise care delivery (Papastavrou, 2012; Schubert et al., 2013). Providing quality care for patients following stroke, are challenged in acute care. Across Europe the majority of patients with stroke are cared for on general medical wards contrary to recommendations of national and international reports (Kings College, 2017). It is therefore timely to explore how nurses care for this patient group in the general acute setting.

Methods

Study Design

This paper develops and expands the concept of care accommodation, a strategy for reducing missed care in the acute care setting forming part of the theory of resigning (O'Donnell & Andrews, 2016) which explains how nurses work within constraints. Classic grounded theory is an inductive and conceptual research methodology which generates theory about issues of concern to participants and how they are dealt with (Glaser, 1978; Glaser, 2007). It is suitable to exploring areas where there is little or no development of theory (Glaser, 2007). Theory development offers an explanation of what is actually happening in a substantive area rather than describing what should be going on. To date literature identifies missed care events, and the reasons this may occur however, few studies have focused on strategies to reduce the incidence of missed care. Classic grounded theory will do this.

Ethical Considerations

All ethical principles were adhered to throughout the research process. Autonomy was assured through gaining informed consent. Involvement in the study was voluntary. Anonymity and confidentiality was assured through use of codes assigned to participants, conceptualisation of data rendering it independent of person, place and time, anonymising of study sites, use of private locations for interview discretion and all data stored on encrypted and managed in accordance with Data Protection Act (Government of Ireland, 2018). Informed consent was obtained before the interview process and maintained throughout the process by reiterating autonomy of participants to cease participation at any time with no repercussion. This study received ethical approved from the relevant research ethical committees which covered multiple hospitals sites in a geographical area, three of which were part of this study.

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Data Collection

Data were collected through unstructured interviews with 32 nurses caring for patients with stroke in the acute care setting. In keeping with classic grounded theory unstructured interviews were used having no pre-determined questions (Glaser, 1998) where the interviewee leads on the interview content.

Following ethical approval potential participants were contacted via letters of invitation and subject information sheets were distributed to all nurses who worked on medical and surgical wards across three hospitals in Ireland weeks prior to agreed participation. Participants contacted the researcher when they were interested in participating in the study. Individual unstructured interviews took place at a venue of their choice i.e. hospital office, a coffee shop or the researcher's office. Participants were allowed time for questions and answers at beginning of interview, allaying any concerns before signing consent forms, protecting their right to autonomy and self-determination. It was anticipated if participants became upset, interviews would cease and time given to consider continuation of interview or not.

Interviews began with informal introductions and thanking participants for their participation. This encouraged ease and allowed time for answering any questions in relation to the study before signing consent form. A broad statement such as 'Can you tell me what are the main concerns and challenges of caring for patients with stroke on a general ward in the acute setting?' began interviews. This statement was broad enough to allow and encourage participants to speak and help relax them to talk more in what Glaser (1998) refers to as a grand tour question. This helped keep the interview unstructured. Following interviews, the researcher remained with participants for debriefing and sharing of support services available if required. No participants required such support.

Following each interview data was analysed, informing the next interview. Within classic grounded theory this process is known as theoretical sensitivity. This encourages constant comparison of the data in identifying recurrent codes and concepts. Writing field notes directly following interviews aided this process. Through active listening and reaffirming the participants' stories and following up with questions on the information shared helped to keep the interviews unstructured. Interviews lasted between 30 – 60 minutes and were digitally recorded and transcribed. Sampling was continued until data saturation reached

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where no new properties emerged for the core category or the sub core categories (Glaser, 1978).

Sampling in different sites and populations is referred to as theoretical sampling. This began following data collection and analyses in one site, following up on concepts which were developed through memo writing, enabling sampling for further ideas to develop concepts and emerging theory (O'Donnell & Andrews 2016). Theoretical sampling supports triangulation of data through remaining open to data, sampling in different sites (medical to surgical wards, within and between different hospitals) and interviewing participants with varying years of experience and professional positions (Table 1). This wide sampling accounted for as much variation of behaviour as possible through theoretically sampling codes and concepts to achieve theoretical coverage.

Analysis

Data collection and analysis occur concurrently. Substantive coding begins with open coding, fracturing of the data into incidents/codes (patterns of behaviour). In the margins of transcripts, patterns of behaviour/codes were recorded. Similar incidents/codes were grouped and named, example in Table 2. Selective coding began when the main concern of working within constraints (O'Donnell & Andrews, 2016) emerged for nurses caring for patients with stroke in the acute care setting (interview 16).

Glaser (1978) advises on allowing interviewing for concept development where every piece of data is coded with previous coding of data in mind. Codes were generated by identifying patterns of behaviour of nurses in caring for patients with stroke (Table 2). For example all nurses spoke of caring for patients by helping them to wash, eat and mobilise. These behaviours were conceptualised as functional caring, which is a property of the sub core category, care accommodation (Table 2) (Figure 1). As interviews proceeded participant's affirmation of concepts emerging were acquired affirming the fit of concepts with the categories and sub core categories. Memoing supported data analysis consisting of connections between codes, categories, recording of ideas, continuous and parallel with coding and analysis (Glaser, 1978).

O'Brien et al. (2019) notes how theoretical coding helps to organise theory and identify relationships between the categories. Theoretical coding was used in conceptualising and

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integrating the substantive codes in demonstrating the relationship and links between all codes forming the theoretical framework. Theoretical coding families were considered (Glaser, 1978) and the main theoretical code used was the degree family (Table 2). As the codes emerged from participants experience they met the Classic Grounded Theory criteria of fit, work, relevance and modifiability.

Results

The focus of this article is on care accommodation, one of the sub core categories in the theory of resigning (O'Donnell & Andrews 2016). Care accommodation is a conceptual explanation of how nurses provide care to patients following stroke in the acute care setting when working within constraints. It comprises of three types of care; functional caring, assisted self-caring and ideal caring. Nurses deal with constraints until they are resolved or reduced, adapting their level of care therefore, as constraints increase, the level of care reduces and missed care may occur (Figure 2). Nurses aim to provide the best level of care feasible at any moment in time.

> "I'm just trying to do my best. When I have more time or resources then I can deliver more care but when its short staffed and we're lacking time then I just get on and do the best I can with what I've got. The way I see it is, it's the very best care I can give at that moment in time. Later if time allows then I can go back and provide more care." (P.9)

This was supported by another nurse:

> "I just have to prioritise what I can do and in doing so try to give the best care possible"
>
> (P.18)

Care accommodation is influenced by the degree of constraint and the level of nurses' commitment to ensuring a minimally acceptable level of care is provided. Missed care is more likely when constraints are high, in turn influencing nurses' resolve to providing ideal care. As one nurse spoke about:

> "I'm strongly committed to giving the best care possible above and beyond basic nursing care to all my patients" (P.22)

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While in contrast another nurse said:

> "When you are constantly faced with shortages then it's just about being able to do what you can and getting the basics done" (P.7)

When nurses are working within constraints, they adapt care to meet the immediate and safe needs of patients. This often involves curtailing care from ideal caring to functional caring, attending to basic care needs first until constraints reduce. Functional caring is central to care accommodation and the most engaged with level of care by all nurses.

Functional Caring

Nurses explain functional caring as attending to patients' needs such as personal hygiene, dressing and assisting patients with toileting needs while also monitoring blood pressure, respirations, temperature, oxygen saturations and colour. All nurses spoke of functional caring. One nurse verbalised this as:

> "It's just quicker to wash the patient [to take the facecloth and wash the patients face] or help the patient to eat rather than waiting for them to do it as that means it's going to take time, time which I don't have". (P.21)

Functional caring ensures patients' comfort, wellbeing and safety but compromises their independence and dignity. Nurses experiencing lack of knowledge, time or help revert to functional caring ensuring immediate needs of patients are met. When constraints increase, functional caring increases. Functional caring ensures that minimum care needs are met until such time as nurses can provide what they consider to be a higher level of care.

Functional caring is visible, therefore measurable, providing evidence that patients' care needs are met. This justifies time spent with patients. One nurse clearly voices this:

> "We had an incident this week when a patient's daughter visited and the first thing she addressed with us was that her mother's nightdress wasn't clean. Not having a changed nightdress reflected to her that her mother hadn't been cared for that day" (P.26)

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Functional caring may be a response to external expectations of others, an attempt to make care delivered visible when working within constraints. Functional caring fits with some people's expectation of what nursing is. Another nurse spoke of

> "We are viewed by many as 'Florence Nightingale' figures providing constant nursing care over 24 hours doing things such as washing, feeding, toileting and dressing, not always seeing or realising that there is more to nursing than attending to basic care needs" (P.13)

It is recognised by nurses as a component of caring however, is often the only type of caring feasible when working within constraints. Nurses resign themselves to delivering functional caring to ensure a minimally acceptable level of care is provided. It is the basis of other types of caring such as assisted self-caring and ideal caring. When working within constraints functional caring may become the best level of care for a period of time until extended to assisted self-caring.

Assisted Self-Caring

Assisted self-caring is nurses supporting and encouraging patients with stroke to care for themselves. It is an extension of functional caring, but the focus is to restore normal functioning needs in a rehabilitative way, such as providing time to walk to the bathroom to wash. Assisted self-caring is dependent on the degree of constraint and nurses' commitment to providing the best care. Assisted self-caring encourages patients to be involved in their care. However, it is dependent on having enough time and adequate resources such as appropriate equipment for patients to care for themselves. Its focus is rehabilitative aiming to restore normal functioning as much as possible. Patient cooperation is required for assisted self-caring to be successful. It is time consuming and frequently forfeited when constraints increase, especially with time pressures.

Role expectations determine care expectations; functional caring is viewed as the nurse's role and assisted-self caring more the role of other healthcare professionals such as physiotherapists. Patients' expectations of nurses' role may also hinder assisted self-caring as demonstrated when one nurse spoke of how:

> "Nurses are always viewed as being there to care, helping patients with hygiene needs and toileting needs. Some patients don't engage with nurses when we try to encourage them with their own care" (P.6).

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Assisted self-caring extends functional caring incorporating restorative function for the patient with stroke. Patient involvement is essential in assisted self-caring. When working within constraints engaging in assisted self-caring makes ideal caring more likely.

Ideal Caring

Ideal caring is when nurses provide the best care to a patient with stroke. It consists of functional caring along with assisted self-caring and advancing further to include patient assessment such as swallowing function, continence and falls assessment as examples while also attending to psychological and emotional care.

Ideal caring is less visible than functional caring involving professional expertise in planning to deliver long term outcomes, only become visible over time along with psychological and emotional support. A consequence of invisibility is that it is often forfeited for either assisted self-caring or functional caring due to increasing constraints. This is also dependent on nurses' commitment to providing ideal caring. The best model of care for patients with stroke is a holistic approach incorporating both functional caring and assisted self-caring including ideal caring. Ideal caring was summarised by one nurse as:

> "…. being able to attend to my patient's immediate needs when asked … helping them to wash, walk to the bathroom, and having a rehabilitative focus to these actions, encouraging and supporting them to do the best they can ... this knowledge of how my patient is doing helps me to further assess and refer to the appropriate healthcare professional to avail of best care when needed" (P.24)

A commitment to providing best care makes ideal caring a greater possibility. In the presence of constraints care accommodation allows for the best type of care to be delivered. This ensures at minimum; basic needs are met. As constraints vary so does care, adapting to support care delivery as prioritised by nurses to meet patients' immediate needs. The greater the increase in constraints the greater the engagement by nurses in care accommodation, consequently reducing the level of care provided to patients with stroke (Figure 2). Care accommodation prioritises how nurses can deliver care.

Discussion

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Care accommodation, is a typology of caring. This explains how nurses respond to fluctuating constraints when caring for patients with stroke. Healthcare environments internationally are operating within constraints making this one of the most challenging aspects of delivering quality safe patient centred care (World Health Organisation, 2017). Care accommodation enables nurses to prioritise and provide safe, quality care to all patients, explaining why care may be missed and can be used as the basis for a rationale for providing more resources. Prioritising safe care is essential (Suhonen et al., 2018). Prioritising care explains what is currently happening in the acute care setting and how nurses come to their decision on what care is needed at a point in time (Suhonen et al., 2018). Care accommodation is a deliberate prioritising of care when working within constraints valuing patient safety rather than a short fall in care leading to missed care. Thus clinical decision making is key when caring for patients (Winsett et al., 2016).

Constraints are always present however; they vary in degrees. Jones et al. (2015) found nurses selecting types of care to provide rather than providing all care. In this study nurses prioritise their care delivery dependent on the degree of constraint. This is often undertaken with safety in mind as Recio-Saucedo et al. (2017) found that not all missed care is of equal consequence with varying patient implications. Recio-Saucedo et al. (2017) also found mixed evidence to support the relationship between missed care and patient mortality. Care accommodation as a typology of caring explains how nurses prioritise care that is safe through engaging in various levels of care, to ensure patient safety potentially reducing mortality and morbidity. Through care accommodation nurses prioritise care within constraints, utilising their knowledge base and clinical decision making skills (Winsett et al., 2016) while also reducing missed care incidents.

Missed care features predominantly in the discourse on care provision with terms varying from missed care (Kalisch et al., 2009), rationing of care (Schubert et al., 2007), unfinished care (Jones et al., 2015). Each term represents a different perspective of reduced care, all acknowledging that full care is not addressed. Research to date on missed care focuses primarily on identifying types and reasons for missed care (Fitzpatrick, 2018). Less explored are interventions and strategies to reduce missed care thus, care accommodation offers a strategy for nurses to use helping reduce the incidence of missed care.

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Environmental factors such as the availability of resources are instrumental in informing nurses' decision making processes (Johansen & O'Brien, 2015). Prioritising of nursing care is dependent on the degree of missing resources, the higher the priority allocated to an aspect of care the more likely it is attended to. Care accommodation attends to this premise as it holds various levels of care however, although functional caring is acknowledged as the most basic level of care, it is the most attended to. This compares to Alfaro-Lefevre (2011) typology of prioritising nursing care, where nurses order care according to patients' immediate care needs from higher to lower priority. Similarly, care accommodation reflects this. Schubert et al. (2013) suggest that prioritising care is influenced by identifying potential complications. Attending to vital signs in functional caring, nurses are prioritising care to ensure patient safety. The levels of care in care accommodation align with Schubert et al. (2013, Pg. 236) 'Informal hierarchical system' used for prioritising patient care. This hierarchical system attends to care influencing patient's health condition first along with the 'monitoring of time' for tasks. The quicker a task is undertaken the higher the probability it is attended to. The levels of care in care accommodation also build on a hierarchical manner to primarily maintain patient safety moving from functional caring to ideal.

Missed care and rationing of care are inevitable occurrences in the presence of fluctuating constraints. How nurses deal with this situation is important. Care accommodation as a typology of caring suggests how nurses can provide care within constraints by prioritising what they do. It challenges the concept of missed care as defined as nurses' omission of care to suggest that nurses consciously and actively prioritise patient care to ensure patient safety. However, care accommodation is acknowledging that some care may be potentially missed to ensure patient safety first and foremost.

Conclusion

Care accommodation provides a unique contribution to missed care discourse, guiding nurses in prioritising care when working within constraints, a modern day reality of global healthcare systems. As a typology of care this helps facilitate and prioritise care for patients with stroke in the acute care setting however, can be generalised to any nurse when working within constraints. Care accommodation helps nurses recognise the situation of working within limited resources, facilitating and supporting the prioritising of patient care helping to reduce missed care. Care accommodation enables nurses to prioritise care adding to the body

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of knowledge on how to better delivery of care when working within constraints, guiding nurses in reducing missed care.

Implications for Nursing Management

This typology of caring has relevance for nursing management as it offers a unique contribution capturing and explaining what is currently happening in clinical practice for nurses caring for patients with stroke in the acute general care setting thus highlighting how incidents of missed care may occur. This typology of caring explains the conditions and the contexts in which missed care may occur building rationale for nursing management to advocate at hierarchical positions for more resources. In identifying this, this paper provides an opportunity for all nurses to reflect on care delivery and how they may reduce missed care incidents. This paper raises questions in relation to levels of care delivered and how competent nurses are in delivering safe care. Safety mechanisms to ensure ideal care is attended to and missed care reduced may include proactive measures such as engagement in clinical audits of practice, safeguarding competent and patient centred care. Management need to ensure that education and training of nurses is required using these research findings. Care accommodation can be used as a framework when mentoring student nurses and nurses and in supporting clinical supervision. These initiatives support clinical practice and help progress practice guidelines. Such engagement by management creates awareness of the importance of care environments and their impact on care delivery which may result in reducing missed care incidents. These findings provide the evidence for change in clinical practice to occur. Management's knowledge of the various levels of care makes them more aware of the pressures of caring in constrained environments and how these measures may lead to missed care. These findings highlight for management the support required in providing appropriate safe care to patients when working within constraints. Understanding the types of care provided will help inform managements decisions on how care is delivered by utilizing research and strategies to reduce missed care. This paper adds to the body of knowledge on care provision and missed care in providing evidence on this challenging area furthermore, this study has relevancy to all nurses working within constraints.

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Table 1 Profile of Participants

Gender	**Age Range**	**Position**	**Years of Experience**	**Educational Qualifications**
Female (30) Male (2)	22 – 29 (7) 30 – 39 (8) 40 – 49 (9) 50 – 59 (6) 60 – 65 (2)	RGN *(25) CNM I *(3) CNM II *(3) CNS Stroke*(1)	1 – 5 (3) 5 – 10 (7) 10 – 15 (4) 15 – 20 (10) 20 – 30 (5) 30 – 40 (3)	BSc Nursing Postgraduate Older Person Postgraduate Palliative Care MSc Nursing MSc Palliative care MSc Nursing Older Person

- RGN* Registered General Nurse
- CNM I * Clinical Nurse Manager 1
- CNM II * Clinical Nurse Manager II
- CNS Stroke* Clinical Nurse Specialist in Stroke

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Table 2 The Audit Trail of a Code

Open codes extracted from the data	Washing patients Dressing patients Walking patients Toileting patients Moving patients Helping patients to eat Taking observations Recording observations Bathing patients
Moving from open coding to Selective Coding	These open codes grouped together as PHYSICALLY CARING FOR THE PATIENT conceptualised to Functional caring
Concept of Functional caring connected to a Category – Care Accommodation	Functional caring explained as a strategy of how care is delivered in Care accommodation
Connection to Core Concept	Care accommodation is a category of Resigning (core concept of main study)
Connection Core Category	Functional caring is a strategy of care accommodation which is a category of resigning which helps nurses to care for patients with stroke in the acute care setting when working within constraints
Theoretical Codes	The degree family was the dominant theoretical code which helped to shape and form the theory providing integration

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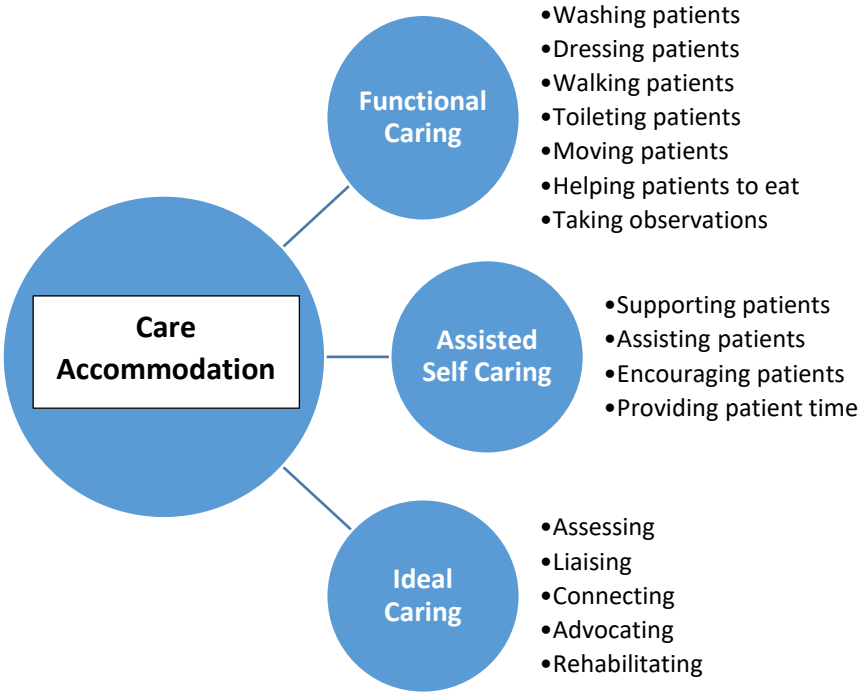
	of substantive codes, categories and relationships to the core concept and core category.

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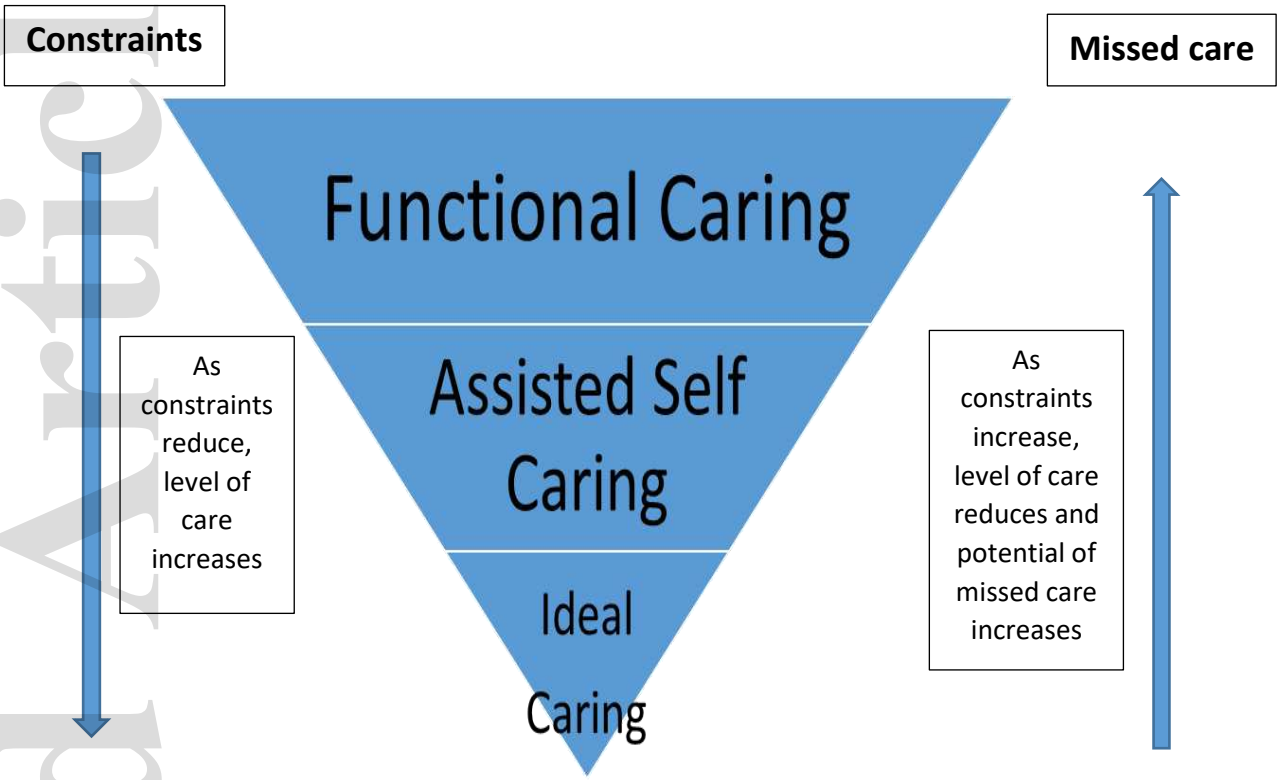
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Figure 1 Care Accommodation:



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Figure 2 Diagrammatic Representation of Connections of Constraints to Levels of Care to Missed Care



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