Exploring Iranian nurses' experiences of missed nursing care: a qualitative study: a threat to patient and nurses' health

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Abstract

Background: The main objective of nursing is to provide comprehensive nursing care that is appropriate to patients' needs. However, the incidence of missed nursing care compromises the provision of comprehensive and safe care and threatens patients' lives. Thus, this in-depth qualitative study aimed to explore nurses' experiences of missed care and factors affecting it. The aim of this study was to describe nurses' experiences of missed care in clinical practice.

Methods: In this study, qualitative research methodology, with a content analysis approach was used. The sample included 23 nurses in referral teaching hospitals. Data were collected through focus group discussions, face-to-face and telephonic interviews, using semi-structured questions.

Results: Three themes, comprising several sub-themes, emerged, and included contextual conditions, coercion, and deprivation.

Conclusion: The results indicated that organizational and personal factors facilitate the incidence of coerced, missed nursing care. High quality of care, the prevention of missed care incidences and patient safety depend on the provision of adequate staff, appropriate equipment and a sense of responsibility for patients' care needs among nurses.

Keywords: Missed, Nursing Care, Patient Safety, Qualitative Research.

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Introduction

Nurses constitute the largest group of health care providers, playing a major role in the provision of high-quality care to patients (1). Their performance is essential in advancing organisational objectives (2,3). Comprehensive nursing care that is appropriate to patients' needs is the main objective of nursing (4,5). However, increases in the provision of emergency services, heavy workloads and staff shortages have a significant effect on the quality of nursing care (6), raising concerns within the nursing community about patient safety in hospitals (5,7).

Missed nursing care is a newly defined concept and refers to any aspect of required patient care that is omitted (either in part or in whole) or delayed. Missed nursing care is an error of omission. The patient safety movement has identified two major types of errors – acts of commission (marking the incorrect eye for surgery) and acts of omission (not ambulating a patient). Acts of commission have received considerable attention in the literature, while acts of omission have been essentially unaddressed (8). Despite its long history, missed nursing care only recently raised widespread concern within the nursing discipline. Despite its prevalence and significance, few studies have explored missed nursing care (9).

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Consumer demand for services has increased disproportionately to the quality of care. Furthermore, consumers are calling for cost control measures for medical services and high-quality care (10). Despite this, missed nursing care persists, highlighting a need to address this phenomenon (4,5).

Iranian nurses are exposed to many work-related challenges that may influence the quality of nursing care (1), resulting in differences in Iran's functional nursing structure and that of other countries. Challenges include staff shortages (1), working immediately after graduation and without any experience (11), lack of work permits, working overtime and having two or three different jobs (12), undefined duties, high workload, defective equipment, low wages and benefits (13), poor social status (1,13), the gap between theory and practice, lack of community-based nursing care, lack of an appropriate student recruiting system, shortcomings in the nursing education curriculum (1) and collaboration with other healthcare professionals (14). Attempts to prevent missed nursing care require in-depth research into the nature of the Iranian healthcare systems. Exploring nurses' experiences of missed nursing care and answering questions such as "How do nurses experience missed care?", and "What factors influence these experiences?" is extremely important; yet, few studies have been conducted in this regard. The importance of this subject in Iran informed this study's focus on nurses' experiences of missed care and factors affecting it.

Methods
Research design
We used qualitative methodology with a content analysis approach. Qualitative content analysis is appropriate for obtaining reliable and valid results from textual data, producing new knowledge, new insights, depicting factual information and providing practical guidelines for action (15-17).

Setting and Sample
In this study, purposive sampling was used. In order to obtain rich information with maximum variability (age, gender, work history, type of employment, type of ward, and working shift), sampling continued until data saturation. The sample included 23 nurses working in various wards within teaching hospitals affiliated to Tehran University of Medical Sciences, with a minimum work experience of 12 months.

Data collection
Data were collected through the researchers' field notes and recorded face-to-face interviews, telephonic interviews and focus group discussions. The majority of the data were collected through face-to-face interviews and field notes. Telephonic interviews enabled the collection of incomplete information. Focus group discussions enabled the investigation of reasons for missed care and discussions between special care unit nurses and general ward nurses. Face to face interviews were conducted according to specified interview guidelines. Interviews began with general questions and, given the participants' responses, became more detailed. The first question was: "Please describe the care that you have given to your patients during a working shift", followed by questions on missed care and factors influencing it. The researchers and participants agreed on a suitable venue and time for data collection. Face to face interviews were conducted in a quiet environment in either the head nurses or researcher's room, whichever the participants chose. We conducted nine face-to-face interviews lasting 30–40 minutes each, five telephonic interviews lasting 10–15 minutes each and two focused group discussions with four or five nurses, each lasting 20–25 minutes. Data were collected over 12 months (2012–2013).

Data Analysis
Conventional content analysis, based on Graneheim and Lundman's (2004) method, was used for data analysis (18). In this

study, the contents of each interview were transcribed immediately thereafter and read several times for comprehension by the researchers and to ensure correspondence with the study's objectives. Then, initial codes were extracted, combined and classified according to similarities. Efforts were made to ensure maximum homogeneity within classes and maximum heterogeneity between them.

Protection of Human Subjects

The research protocol was approved by institutional ethical committee providing protection of human subjects (research project number 458).

Results

Participant Characteristics

Participants included 23 nurses (7 men and 16 women); of whom, 79% held a Bachelor's degree. The participants were aged 25–37 years, with a mean work experience of 8.4 ± 2.2 years; 66% worked night shifts and 59% were employed on contract.

Content Analysis Results

Contextual conditions, coercion and deprivation were conditions affecting care behaviour and missed care by staff nurses and are described below. In turn, several subthemes could be attributed to each of these three main themes (Table 1).

Contextual Conditions

Contextual conditions include system and management failures and team disintegration, resulting in missed nursing care and, subsequently, deprivation of nursing services.

System and Management Failure

Missed nursing care occurs due to staff and equipment shortage in the wards and an unfavourable organisational environment. Nursing staff shortage was the leading cause of missed care, resulting in the employment of inexperienced nurses, graduate nurses and nursing students. Non-professionals such as auxiliary nurses, medical assistants, service workers and patient's companions performed specialised nursing duties. This decreased nursing care quality threatens patients' lives and results in higher error margins and missed nursing care. A novice nurse, working the night shift and being recently transferred to the internal ward, said of a patient needing intake-output control:

"Sometimes we are forced to ask service workers to empty a patient's urine bag… therefore, we did not realise that the patient had anuria and he lost consciousness."

Staff distribution according to the health care system differs according to wards and the types of services provided. Missed care is less probable in special care units, as these require a relatively high number of experienced nursing staff, also offering more opportunities for in-service training and specialised courses for the personnel compared to other wards. In these wards, nurses feel that they have more autonomy and authority. A nurse with a master's degree and 6 years' working experience in Coronary Care Unit (CCU) and internal wards, on a night shift for which she was responsible, asserted:

"Ever since I was transferred to CCU, I have hardly missed care. Here, facilities and equipments help us provide better quality of care, but I looked after 20 patients in

Table 1. The Themes and Subthemes of This Study

Themes	Subthemes
Contextual Conditions	System and Management Failure
	Team Disintegration
Lack of Staff Effectiveness	Lack of Motivation
	Affectability
Coercion	Silent Care
	Escape
	Deprivation

the internal ward."

The limited number of public hospitals which are considered cheap hospitals, and high admission levels have led to patient overcrowding in wards so as to cover patients' financial constraints. This has resulted in staff shortages and a higher workload for nurses. Staff shortages, especially in the emergency ward (with unpredictable and uncontrollable admissions) are more conspicuous, forcing nurses to transfer patients to any non-specialised ward with vacant beds. This exacerbates the failure of health care system. An emergency ward nurse on a night shift, with a three years' experience, stated:

"We have no choice, and have to empty beds for admission of emergency patients. That is why we send them to any ward. Well, in all this chaos and disorder, we miss some of the care."

Nurses considered the shortage of facilities as an important factor in missed care. Old equipment, shortage of disposable goods and the unaffordability of new and advanced tools partially constitute system failure. These factors result in longer equipment preparation times, burnout and fatigue among nurses and can compromise nurses' safety. In turn, these are accompanied by threats to patient safety, patient dissatisfaction and treatment discontinuation. An orthopaedic nurse often working on evening and night shifts stated:

"A patient once aspirated and due to the lack of a catheter, we could not clear the secretion in time; the patient became comatose and was subsequently transferred to the ICU (intensive care unit)."

Head nurses and nursing managers facilitate the provision of quality care. However, in this study, lack of planning, as well as superficial and insufficient supervision were glaringly obvious. Planning often meant improper and inadequate delegation of duties and the use of relief nurses who are unfamiliar with the ward. Moreover, ineffective management resulting from adverse systemic conditions and inadequacies imposed a high workload on nurses. Exam-ples of these are a low nurse-patient ratio or allocation of patients to unskilled individuals (e.g., nursing students). A novice nurse working in the internal ward said:

"During some shifts, I have to look after as many as 30 patients, assisted by only one healthcare worker. By the time I have finished administering their 2 pm medication, it is 6 pm and I have to administer their 6 pm medication. Moreover, I am in charge of the shift and have to write all of the patients' reports."

In addition to poor planning, supervision of nurses' performance is not without flaws. Merely monitoring registers without considering care practices constitutes superficial and shallow supervision only aimed at catching out offenders in the wards. A recently qualified nurse stated:

"No one at all asked if care had been provided or not. Even if they found out, they pretended otherwise. The supervisor only checks records and patients' notes and is not much bothered about care."

Team Disintegration

When providing patient care, nurses have to collaborate with other treatment team members, especially doctors. Team disintegration occurs in different forms, including the lack of communication and collaboration between nurses and doctors, and the authority of doctors and service provision that is overshadowed by that of doctors. A nurse with a master's degree and six years of work experience in the ICU said:

"A nurse is practically nobody and obeys the doctor blindly, has low self-esteem and has to say 'Yes Sir' to the doctor, and this has led to the doctors' mistrust and mistreatment of the nurses."

Lack of collaboration between doctors and nurses was more obvious, especially in teaching hospitals and during evening and night shifts. This was evidenced by the constant issuing of orders in writing or verbally by medical students and doctors in the absence of nurses, and without consulting or informing them. This has resulted in a high workload for nurses. An emergency

ward nurse said:

"The majority of missed care occurs due to verbal instructions by doctors. Believe me, we do not want to obey these instructions, but here, you cannot argue with doctors. Sometimes, even without our knowledge, doctors visit patients and leave."

Lack of Staff Effectiveness

This category comprises two subcategories: Lack of motivation and affectability.

Lack of Motivation

Nurses identified disinterest, dissatisfaction with the nursing profession and laziness as factors associated with the ineffectiveness of nursing staff. A novice nurse with a master's degree who worked in the oncology ward stated:

"Some people are naturally happy-go-lucky; perhaps they are not interested in nursing and only come to clock-in and go. I feel that missed care occurred because my colleague was not interested in the work."

Lack of accountability, not considering patient needs, failure to follow up, covering up and frequent missed care which result in habitual missed care had an impact on missed nursing care. A male nurse currently working in the orthopaedic ward confessed:

"Well, I confess that I am not precise in checking the file and doing what I am told. I take blood pressure, but not pulse, respiration, or temperature; I think it is a waste of time."

Affectability

Working alongside negligent and perfunctory colleagues affects nurses. Observing behaviours such as ridiculing care based on standard nursing procedures and principles, non-supervision of new nurses and delegation of duties from peer nurses to them resulted in observation of missed care incidents. A nurse with one year's experience, currently working on night shifts in the neurology ward, stated:

"For instance, legally, we ought to check vital signs at 6 pm and 6 am. None of my colleagues takes the 6 pm one. Sometimes I see that they have scribbled up something at 12 midnight and leave. They think it is a waste of time so I have become indifferent towars my duties."

Coercion

This theme comprised three categories of silent care, escape and deprivation. The participating nurses argued that widespread, missed nursing care depended on an unsuitable working environment. Nursing staff shortages resulted in low nurse-patient ratios. Those working in a busy wards, sometimes alone, provide highly demanding care, resulting in exhaustion and fatigue. These nurses may miss vital care details while performing their duties.

Silent care

Nurses in this study stated that, due to managerial and systemic requirements and barriers, they are sometimes compelled to miss care, given the need to prioritise care provision. Usually, this prioritising is done in accordance with the working system's expectations, doctors' preferences and the nurse's role within the system. The nurses prioritised care in instances of missed care such as patient and family education, interrupted training, training irrespective of needs, conditions or level of a patient's learning, and minimal contact with a patient or mental/emotional missed care toward him. Nurses typically prioritised immediate and primary care, such as administering medication, Intra Vessel therapy and activities that are observable to managers. A female nurse working in the CCU, with six years' work experience said:

"Often, we do not have the time to communicate with patients. We talk to (them) about their illness, diet, etc. when inserting an IV line. I prioritise my work according to the time I have. Nursing officials and even doctors only care about appearances."

Escape

Staff shortages and a high-pressure environment mean that nurses do not enjoy organisational support, resulting in 'escape'. Escape manifests in time wasting, long periods spent handling admissions and reports, performing peripheral and non-nursing duties or selective care based on a patient's self-assessment without conducting appropriate examinations and providing routine-oriented care. A nurse working in the surgery ward, usually caring for a large number of patients stated:

"I get so tired that sometimes I try to pass time on my shift by writing patient files and notes; when I walk by and see that the patient is OK, I do not bother to go in and check his/her vital signs."

Nurses feared being confronted by the nursing manager, which induced threats about their current position and fear of legal punishment. This resulted in escape, demonstrated by failure to report missed care or faking care. A male nurse with two years' work experience, working in the surgery ward and often not checking TPR stated:

"I falsely recorded that I performed care and did not tell the head nurse or the doctor; I knew that they would be angry and tell me off."

A non-supportive occupational environment also resulted in nurses' failure to report missed care, in turn leading to despair, frustration and feelings of powerlessness. A nurse with eight years' work experience in various wards said:

"So far, not even once, have nursing managers ever supported me. Whenever there is a problem (regarding the patient), even when the system is to blame, they blame us in front of doctors or patients."

Escape also manifested when nurses listed care without considering quality, provided care only upon the patient's request or if the patient was extremely sick (care according to conditions like staff and time), self-imposed timing of care and eliminating care. A new nurse, working rotating shifts in the surgery ward, confessed:

"For example, if the patient had dyspnoea and really needs and asks for oxygen, then I would give him/her oxygen."

Deprivation

Contextual conditions and coercion in missed care resulted in deprivation, which affects patients and nurses. Deprivation comprised four subcategories of ethical distress, burnout, compensation and sublimation. In this study, most cases of nursing care deprivation related to the education of patients and their families about a medical condition and how to manage it, or education relating to discharge and personal hygiene. The second instance of missed case in this regard related to psychological/emotional missed care, demonstrated by indifference towards patients' concerns, lack of empathy or a caring relationship with the patient and failure to respond to patients' questions about a disease and its prognosis.

The deprivation theme alludes to the effects of missed care on both nurses and patients. Whenever a nurse tried to make up for the missed care of a patient, other patients' care was either missed or delayed, leading to longer hospitalisation periods, higher medical costs and even death. A nurse with three years' work experience, working in the ICU, stated:

"I remember one night Code Blue was paged for a patient. Unfortunately, the catheter in the vein receiving dopamine was out, and I had forgotten to control the patient's IV line. Code Blue was paged again for this patient and, unfortunately, he died."

Discussion

Due to unfavourable systemic conditions of health care and personal factors, missed nursing care is prevalent in Iranian hospitals, affecting patients, nurses and the entire health care system. Nurses considered systemic and managerial failures, which constitute contextual factors, as the most important contributors towards missed care. In their opinion, staff shortages, patient overcrowding, lack of proper medical facilities

and equipment and an unfavourable organisational environment posed major problems in the public healthcare systems. Employing graduate and student nurses to compensate for staff shortage is stipulated in Iranian healthcare policies; this has implications for patients, the nurses and the public healthcare systems (12). Often, nurses lack time management skills, especially in facing with patients critical conditions. Furthermore, they are not allocated to wards according to their scientific, physical and mental capabilities. Their lack of familiarity with equipment and facilities in patient care units often lowers the quality of care, compromising patient safety and their own. Loss of motivation, frustration and job dissatisfaction are consequences of a high workload among these nurses(19).

Adopting appropriate guidelines to ensure the quality and adequacy of human resources by managers and policy makers improves productivity and ensures safe care, (1, 20) saving patients from many complications related to staff shortages(12). Nurses considered time wasting due to faulty, old equipment and the lengthy repair process, limited knowledge regarding operating the equipment and time spent locating the equipment or borrowing it from other wards as factors associated with system failure. This led to distress and job dissatisfaction among nurses (21). The availability of equipment required for patient care ensures patient safety, enhances the quality of care and results in better time management among nurses. The relationship is the primary principle in team working and requires international attention (20, 22).

Focus on the quality of care without staff teamwork is not possible (4, 23). Most nurses emphasised staff incompetence as a contextual factor in missed care, considering nurses' motivation levels, accountability towards patients in relation to the care being provided, and a caring attitude as effective care behaviours. Passion for the nursing profession and the selection of nursing volunteers according to their career interests and nurses' physical, emotional and psychosocial health were considered equally important (24, 25).

Participants also regarded the non-standard structure of wards as a contributor towards the time taken by nurses to reach patients and, consequently, fatigue. Such conditions complicate patient supervision and the provision of follow-up care (26). Another contextual factor in the missed care incidences was inefficient management in relation to planning and supervision. Functional care as a duty has had a huge impact on staff performance. Nurses typically focus on the application of the biomedical model and acquiring technical skills relating to the nursing profession. This leads to poor patient care, given the assumption of a mechanical approach towards a totally humane job (27).

Inefficiencies due to poor supervision or management and unfavourable outcomes in this regard lead to feelings of being abused by the system and general dissatisfaction (12). According to management theories, managers play an important role in employees' job satisfaction (28). Moreover, team disintegration has a negative effect on the quality and continuity of care by undermining the nurses' role in patient care. The role of doctors is an important aspect to consider in any quality management plans relating to patient care (4, 29, 30). Nursing managers could increase accountability, professional ethics and self-efficacy among nurses by emphasising the importance of ethics and creating a favourable work environment (10). Participants also regarded colleagues' influence as a contributing factor towards missed care. This can lead to assumptions that patients do not really need care, failure to attach importance to care, magnification of nursing job problems, colleagues' exposure to fraudulent report writing practices and habitual missed care. This gradually decreases interest in the job and commitment to the profession and results in indifference towards professional duties and patient needs, as well as lower quality of care (29, 30). Nurses regarded contextual conditions as a

contributing factor towards silent care and mental or emotional missed care, characterised by avoiding contact with patients. Lower patient contact results in lower quality of care (31, 32). Quoting Morse, Atashzadeh (2011) states that care comprises interaction between humans and has a mutual impact on social actors. It is in this human interaction that patient education is rendered meaningful (10).

Nurses also reported that low patient contact constituted mental and emotional missed care, citing functional care as a reason. In this regard, the patient is not regarded as a unit; rather, nurses may ignore some of the patient's needs due to not knowing all of his/her needs especially mental, emotional and social needs. Working conditions that are not conducive to efficient performance of duties have led to the adoption of escape strategies by nurses, such as routine-oriented care. This approach is flawed; there is consensus among all nursing experts to engage in collective efforts to replace it with patient-oriented approaches (24). Failure to report missed care is one of the typically adopted escape strategies. Reasons for not reporting missed care include considering missed care as unimportant, fear of legal complications, or loss of own position within the system or with confirmation by colleagues and patients. This finding is similar to the results of a study by Mohammadnejad (2013). Investigating the causes of missed care with the cooperation of nurses and nursing managers is important for preventing missed care (33).

Missed nursing deprives both nurses and patients like threatening patients' safety and burn out for the nurse. In the current study, the education of patients and families was cited as the most frequent instance of missed care. However, in Kalisch's study (2009), educational missed care ranked fifth (8). Education is acknowledged by nursing experts as the most important factor in improving patient health, enhancing nursing care quality and patient safety (9). In a study by Winter 2005, delayed or missed care relating to observing or monitoring patients' vital signs was the most common type of missed care (21).

Conclusions

The results obtained from this study showed that many organisational and personal factors influence missed care among Iranian nurses. Addressing staff shortages to counter missed care should be a priority in the healthcare system. Nursing managers should address this by creating a culture of teamwork, attending to nurses' roles in patient care, reviewing job descriptions and work allocation, facilitating training opportunities before and during service and obtaining feedback on nurses' performance. Nursing managers could also set up systems enabling nurses to report missed care and use nurses' accounts to reduce incidences of missed care.

The study findings could inform strategy planning at an international level, aimed at reducing missed care and improving patient safety.

Acknowledgment

References

1. Farsi Z, Dehghan-Nayeri N, Negarandeh R, Broomand S. Nursing profession in Iran: an overview of opportunities and challenges. Japan Journal of Nursing Science 2010;7(1): 9-18.

2. Laschinger HKS, Purdy N, Almost J. The impact of leader-member exchange quality, empowerment, and core self-evaluation on nurse manager's job satisfaction. Journal of Nursing Administration 2007;37(5): 221-229.

3. Morrison RS, Jones L, Fuller B. The relation between leadership style and empowerment on job satisfaction of nurses. Journal of Nursing Administration 1997. 27(5): p. 27-34.

4. Schluter J, Seaton P, Chaboyer W. Understanding nursing scope of practice: A qualitative study. International journal of nursing studies 2011;48(10): 1211-1222.

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5. Kalisch BJ, McLaughlin M, Dabney BW. Patient Perceptions of Missed Nursing Care. Joint Commission Journal on Quality and Patient Safety 2012;38(4): 161-167.

6. Long LE. Imbedding quality improvement into all aspects of nursing practice. International journal of nursing practice 2003;9(5): 280-284.

7. Kunaviktikul W, Anders R.L, Srisuphan W, Chontawan R, Nuntasupawat R, Pumarporn O. Development of quality of nursing care in Thailand. Journal of advanced nursing 2001;36(6): 776-784.

8. Kalisch BJ, Landstrom GL, Hinshaw AS. Missed nursing care: a concept analysis. Journal of advanced nursing 2009; 65(7): 1509-1517.

9. Kalisch BJ. Missed nursing care: a qualitative study. Journal of nursing care quality 2006;21(4): 306-313.

10. Atashzadeh SF, Ashktorab T. Factors influencing implementation of nursing process by nurses: A qualitative study. Knowledge and Health 2011;6(3): 16-23.

11. Rafii F, Oskouie SH, Nikravesh M. Conditions Affecting Quality of Nursing Care in Burn Centers of Tehran. Iran Journal of Nursing 2007; 20(51): 7-24.

12. Dehghan Nayeri N, Nazari A, Salsali M, Ahmadi F, Adib Hajbaghery M. Iranian staff nurses' views of their productivity and management factors improving and impeding it: a qualitative study. Nursing & health sciences 2006;8(1): 51-56.

13. Nasrabadi AN, Lipson JG, Emami A. Professional nursing in Iran: an overview of its historical and sociocultural framework. Journal of professional Nursing 2004; 20(6): 396-402.

14. Nikbakht Nasrabadi A, Parsa Yekta Z, Emami A. Phenomenological study of nursing experiences in Iran and Sweden. Journal of Tehran nursing and Midwifery College (hayat) 2003;10(3): 23-30.

15. Elo S, Kyngäs H. The qualitative content analysis process. Journal of advanced nursing 2008; 62(1): 107-115.

16. Polit D, Beck C, Hungler B. Essentials of Nursing Research, Methods, Appraisal and Utilization. 2006. Lippincott Williams & Wilkins, Philadelphia. 2: p. 11-23.

17. Polit DF. Essentials of nursing research: Appraising evidence for nursing practice. 2013: Lippincott Williams & Wilkins.

18. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse education today 2004;24(2): 105-112.

19. Miller PE. The relationship between job satisfaction and intention to leave of hospice nurses in a for-profit corporation. Journal of Hospice & Palliative Nursing 2008;10(1): 56-64.

20. Vaismoradi M, Bondas T, Salsali M, Jasper M, Turunen H. Facilitating safe care: a qualitative study of Iranian nurse leaders. Journal of Nursing Management 2012:p. 1-11.

21. Winters R, Neville S. Registered nurse perspectives on delayed or missed nursing cares in a New Zealand Hospital. Nursing praxis in New Zealand inc 2012; 28(1): 19-28.

22. Pazargadi M, Zagheri Tafreshi M, Abed Saeedi Z. Nurses' perspectives on quality of nursing care: a qualitative study. Pejouhesh 2007;31(2): 155-158.

23. Kalisch BJ, Lee KH. The impact of teamwork on missed nursing care. Nursing Outlook 2010; 58(5): 233-241.

24. Hughes RG. Nurses at the "sharp end" of patient care. 2008. Chapter 2 Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Available at: http://www.ncbi.nlm.nih.gov/books/NBK2672/.

25. Reid J, Catchpole K. Patient safety: a core value of nursing-so why is achieving it so difficult? Journal of Research in Nursing 2011; 16(3): 209-223.

26. Brooten D, Youngblut JM. Nurse dose as a concept. Journal of Nursing Scholarship 2006; 38(1): 94-99.

27. Parsayekta Z, Nikbakht Nasrabadi A. Caring: a concept analysis. Modares journal of medical sciences 2005;7(2): 31-39.

28. Bloom JR, Alexander JA, Nuchols BA. Nurse staffing patterns and hospital efficiency in the United States. Social science & medicine 2006; 44(2): 147-155.

29. Baljani E, Azimi N, Hosseinloo A. A survey on nurse's perception of the importance of caring beha viors and factors affecting its provision. Evidence based care 2012; 2(1): 13-21.

30. Keshtkaran A, Kavosi Z, Gholipour A, Sohrabi Zadeh S, Sharafi Z. Work Engagement & Effective Factors Among Nurses In General Teaching Hospital Of Shiraz University Of Medical Sciences. Payavard Salamat 2013;6 (2): 147-156.

31. Hallin K, Danielson E. Registered nurses' experiences of daily work, a balance between strain and stimulation: A qualitative study. International journal of nursing studies 2007;44(7): 1221-1230.

32. Fakhr-Movahedi, A., et al., A qualitative content analysis of nurse–patient communication in Iranian nursing. International Nursing Review 2011; 58(2): 171-180.

33. Mohammadnejad E, Ehsani KK SR, Salari A, Sajjadi A, Hajiesmaeelpour A. Refusal in reporting medication errors from the perspective of nurses in emergency ward. Journal of research development in nursing & midwifery 2013;10(1): 61-68.