GUEST EDITORIAL

Bedside Rationing of Nursing Care: a European Union Response

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Policy makers and healthcare organisations face an ongoing challenge to provide safe and effective care to patients. This challenge exists in a context of global and local economic constraints, increasing patient numbers, shorter patient stays, increasing complexity in treatment options, higher expectations from the general public, increased media focus on patient safety failures, and crucially declining numbers of key healthcare staff such as nurses. While policy makers and healthcare managers address the challenges through policies, guidelines and movement of resources, nurses in direct care provision make decisions on a daily basis which impact directly on patients. When staffing levels and resources are deemed insufficient to provide high quality care to all patients, nurses frequently use their clinical judgement to prioritise how they allocate their time and skills. This bedside rationing of care can impact negatively on patient outcomes (1) and, therefore, needs further scrutiny.

The term *rationing of nursing care* has developed through a series of iterations from *nursing care left undone* (2) or *unfinished care* due to time constraints (3), through *missed nursing care* (4), and *unmet nursing needs* (5). All of these terms are associated with local decision-making by clinical nursing staff rather than by hospital managers or policy makers. Clinical nursing staff, when faced with reduced resources while striving to provide care, may be forced to make choices which impact on care delivery and patient safety. Evidence suggests that the level of rationing of nursing care may be as high as 55%–98% in acute care hospitals internationally. Implicit rationing of care is not unique to nursing; it has also been described in relation to physicians who feel compelled to ration essential care for patients due to financial constraints (6).

Critically, the nursing care most frequently rationed is that which addresses the emotional and psychological needs of the patient, rather than the physiological needs (7). This may be because the time required to provide this care is frequently unpredictable, and when time is limited, nurses choose to forego this less measurable care. Another concern arising from rationing of care by nurses at the bedside is how the choices are made. Are nurses choosing which care is rationed within an ethical framework? Or are they at risk of discriminating between patients based on reasons other than immediate care need? Could choices be made based on age? On gender? On ethnic origin? The decision to ration care comes at a cost to patients primarily, but significantly also to nurses and the organisations in which they work, and puts the core values of nursing at risk. Compassion and empathy may be lost as nurses strive to provide care which addresses only the physiological needs of their patients.

In February 2016, a European Union COST Action was approved which is intended to facilitate a debate on the conceptualisation of the phenomenon of rationing of nursing care, and explore the methodological challenges associated with investigating the phenomenon. COST Action CA15208: "Rationing – Missed Nursing care: An international and multidimensional problem (RANCARE)" is led by Professor Evridiki Papastavrou from Cyprus University of Technology who has conducted extensive work in this area previously (7). Research around the issue of rationed nursing care frequently centres on negative patient safety outcomes, how the phenomenon can be systematically measured, and the ethics and decision-making associated with the concept of rationing. This Action is designed to facilitate an international exchange of expertise and knowledge across Europe and the wider international community. It is intended to "facilitate stakeholders to develop a responsive research agenda that identifies challenges and innovative cost-effective and patient-centred solutions associated with care rationing" (http://www.cost.eu/COST_Actions/ca/CA15208?). Twenty-seven European countries are involved in this Action, the work of which has been broken down into four working groups (WG). In line with previous research, the focus of these working groups is as follows:

WG1: Conceptualisation of rationing and research methodology;

WG2: Evidence-based interventions and intervention design;

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WG3: The ethical dimension of rationing of nursing care;

WG4: Educational issues and training.

Each working group is led by an international expert and has defined objectives and outputs. Professor Olga Riklikienė from the Lithuanian University of Health Sciences is leading Working Group 4. Emerging from this working group, a survey is currently taking place across all participating countries to examine how patient safety is integrated in the nursing curricula in these countries. Preliminary results will be available in the second half of 2017 and will be used to make recommendations about patient safety teaching for undergraduate nurses across Europe. The impact of rationing of nursing care is potentially far reaching, with adverse outcomes for patients, nurses and organisations. It is essential that newly qualified nurses are adequately prepared for a practice environment in which patient safety and patient outcomes remain central to all decision-making.

The RANCARE initiative acknowledges the phenomenon of rationing in nursing and its impact on patient safety. This four-year Action will lead to further research in the area based in new and existing collaborations between European experts and partners from the US, Australia, New Zealand and Canada. By advancing our understanding of the contemporary problem of rationing, we can address its causes and minimise its impact on patients, nurses and organisations, in these challenging times for healthcare.

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