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Research Article

Multidimensional Analysis of Clinical Status and Influencing Factors of Missed Nursing Care in Operating Rooms

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Abstract

Objective: To investigate and analyze missed nursing care among operating room nurses in clinical practice, and propose targeted strategies to improve nursing quality. **Methods:** The Chinese version of the Operating Room Missed Nursing Care Scale was adopted. A convenience sampling method was used to recruit 120 operating room nurses from hospitals at all levels in Guangdong Province from November to December 2025 for questionnaire surveys. SPSS 26.0 software was applied for statistical analysis. **Results:** The total score of missed nursing care among operating room nurses was (20.75±17.56), with an average item score of (0.74±0.63). The top three causes of missed nursing care ranked by score were "intraoperative changes including modified or additional surgical procedures" (2.54±0.72), "heavy surgical volume with a large number of critically ill patients" (2.49±0.71), and "sudden patient emergencies accompanied by unstable vital signs" (2.48±0.79). Multiple linear regression analysis indicated that overtime frequency (β=0.308, P<0.001), weekly working hours (β=0.253, P=0.003), and average daily surgical volume (β=0.172, P=0.038) were independent influencing factors of missed nursing care. **Conclusion:** The overall incidence of missed nursing care among operating room nurses remained at a low level, yet the intraoperative phase represented a high-risk area for missed care. Overtime frequency, working hours and average daily surgical volume constituted major contributors to missed nursing care. Nursing administrators should optimize human resource allocation, arrange working hours rationally, and monitor nursing quality in high-workload departments.

Keywords: Operating Room Nursing; Missed Nursing Care; Influencing Factors; Workload; Patient Safety

Introduction

The operating room serves as a core setting for surgical treatment in hospitals, and the quality of nursing services here directly determines patient safety and surgical outcomes [1]. Perioperative nursing covers preoperative preparation, intraoperative collaboration and postoperative care, all of which are equally critical. Nevertheless, missed nursing care (MNC) [2] frequently occurs in routine operating room practice due to multiple interfering factors. The concept of missed nursing care was first proposed by American scholar Kalisch [3] in a qualitative study in 2006. A systematic concept analysis was completed in 2009, defining MNC as "any required nursing intervention for patients that is partially or fully omitted or delayed". Essentially, MNC refers to the omission of essential nursing actions, which inevitably degrades nursing quality and endangers patient safety. Missed nursing care is a worldwide prevalent phenomenon; Kalisch et al. [4][5] documented its widespread existence across three hospitals in the United States. Comprehensive understanding of MNC and its research progress is vital for improving nursing quality and safeguarding patient safety.

In recent years, continuous advancements in medical technology and rising patient expectations for healthcare services have elevated the significance of perioperative nursing, alongside growing scholarly attention to missed nursing care. MNC exerts multiple adverse impacts on patient safety and surgical prognosis: it elevates risks of surgical errors and postoperative complications, impairs nurses' occupational wellbeing and mental health, disrupts team atmosphere, and in severe cases threatens patients' lives [6]. Existing research [7] confirms that defects in perioperative nursing management and workflow represent the primary source of safety hazards in operating rooms. Currently, domestic research attention toward operating room MNC remains insufficient, and its influencing factors have not been fully clarified [8]. Accordingly, this study targets operating room nurses to investigate the prevalence of missed nursing care, with the aim of improving perioperative nursing quality and protecting patient safety throughout the surgical journey.

Subjects and Methods

Research Subjects

A convenience sampling strategy was adopted to recruit operating room nurses from geographically diverse hospitals in Guangdong Province between November and December 2025. **Inclusion criteria:** holding a valid registered nursing license, having at least 1 year of working experience in operating rooms, and voluntary participation in this survey. **Exclusion criteria:** nurses recently assigned to major emergency rescue missions, or those on leave or further training during data collection. A total of 120 operating room nurses were enrolled. One hundred and twenty questionnaires were distributed and all were returned with complete valid responses, yielding an effective response rate of 100%.

Research Instruments

(1) General Information Questionnaire: covers demographic variables including gender, age, educational background, professional title, hospital tier, and weekly working hours.

(2) Chinese Version of Operating Room Missed Nursing Care Scale (OR-MNCS): The original scale was developed by Marsh V et al. [9], and translated and culturally adapted into Chinese by Shang Yixian et al. [10] to measure the frequency and contributing factors of missed perioperative nursing care. **Section A:** Missed Care Item Scale, containing 28 items scored on a 5-point Likert scale (0 = Never missed, 1 = Rarely missed, 2 = Occasionally missed, 3 = Frequently missed, 4 = Always missed). Higher total scores indicate a greater number of omitted nursing interventions. **Section B:** Causes of Missed Care Scale, consisting of 16 items with a 4-point Likert rating (0 = Not a cause of missed care, 1 = Minor cause, 2 = Moderate cause, 3 = Major cause). Higher scores correspond to stronger contributing factors for missed nursing care.

Data Collection Procedures

Online questionnaires were distributed via the Wenjuanxing platform. Trained researchers explained the study objectives and completion guidelines to all participants. Questionnaires with incomplete responses or logical inconsistencies were excluded after collection. The final valid response rate reached 100% (120/120).

Statistical Analysis

SPSS 26.0 software was used for all statistical analyses. Measurement data were expressed as mean ± standard deviation ($\bar{x}\pm s$); enumeration data were presented as frequencies and percentages (%). Independent-sample t-test was used for comparisons between two groups, and one-way analysis of variance (ANOVA) for multi-group comparisons. Multiple linear regression with the Enter method was applied for multivariate analysis. The significance level α was set at 0.05; $P<0.05$ was considered statistically significant.

Results

Demographic Characteristics of Participants

Among the 120 enrolled operating room nurses, 40 were male

(33.3%) and 80 were female (66.7%). The dominant educational attainment was bachelor's degree (91 nurses, 75.8%), followed by junior college diploma (17, 14.2%), postgraduate degree or above (11, 9.2%), and high school/secondary technical school (1, 0.8%). In terms of professional titles, 67 nurses held titles of Nurse or below (55.8%), 42 were Supervisor Nurses (35.0%), and 11 were Associate Chief Nurses or higher (9.2%). For working tenure, 16 nurses had ≤3 years of experience (13.3%), 62 had 4–10 years (51.7%), 30 had 11–20 years (25.0%), and 12 had over 20 years (10.0%). Eighty participants (66.7%) worked in tertiary hospitals, 37 (30.8%) in secondary hospitals, and 3 (2.5%) in primary hospitals. Weekly working hours were concentrated between 30–60 hours (83 nurses, 69.2%); 34 nurses (28.3%) worked over 60 hours weekly, while only 3 (2.5%) worked less than 30 hours. Regarding overtime frequency, 14 nurses (11.7%) reported no weekly overtime; 63 (52.5%) worked overtime 1–3 days per week, 26 (21.7%) 4–6 days, and 17 (14.2%) every day of the week. For average daily surgical volume, 23 nurses (19.2%) handled fewer than 20 cases, 87 (72.5%) managed 20–59 cases, and 10 (8.3%) dealt with 60–100 cases daily (Table 1).

Variable	Category	n	Proportion (%)
Gender	Male	40	33.3
	Female	80	66.7
Educational Background	High/Secondary Technical School	1	0.8
	Junior College	17	14.2
	Bachelor's Degree	91	75.8
	Postgraduate and Above	11	9.2
Working Tenure	≤3 years	16	13.3
	4–10 years	62	51.7
	11–20 years	30	25
	>20 years	12	10
Professional Title	Staff Nurse and Below	67	55.8
	Supervisor Nurse	42	35
	Associate Chief Nurse and Above	11	9.2
Hospital Tier	Tertiary Hospital	80	66.7
	Secondary Hospital	37	30.8
	Primary Hospital	3	2.5
Weekly Working Hours	<30 h	3	2.5
	30–60 h	83	69.2
	>60 h	34	28.3
Weekly Overtime Frequency	No overtime	14	11.7
	1–3 days/week	63	52.5
	4–6 days/week	26	21.7
	7 days/week	17	14.2
Average Daily Surgical Volume	<20 cases	23	19.2
	20–59 cases	87	72.5
	60–100 cases	10	8.3

Table 1: Demographic characteristics of participating operating room nurses (n=120).

Prevalence of Missed Nursing Care

The total missed nursing care score across all 120 nurses was 20.75±17.56, with an average item score of 0.74±0.63. Stratified by perioperative phase, the intraoperative dimension yielded the highest mean score of missed care (9.79±8.21), followed by the preoperative phase (8.83±7.61), while the postoperative phase presented the lowest missed care score (2.13±2.27) (Table 2).

	N	Minimum	Maximum	Mean	Standard Deviation
Preoperative Care Score	120	0	35	8.83	7.609
Intraoperative Care Score	120	0	38	9.79	8.21
Postoperative Care Score	120	0	11	2.13	2.275
Total Missed Care Score	120	0	84	20.75	17.562

Note: The scale ranges from 0 to 4; higher scores indicate more severe missed nursing care.

Table 2: Subscale scores of missed nursing care across perioperative phases (n=120).

Analysis of Causes for Missed Nursing Care

Table 3 lists the top 5 items with the highest scores among the 16-item Causes of Missed Care Scale.

	N	Minimum	Maximum	Mean	Standard Deviation
Intraoperative adjustments including modified or additional surgical procedures	120	0	3	2.54	0.721
Excessive surgical volume with numerous critically ill patients	120	0	3	2.49	0.71
Sudden patient crises accompanied by unstable vital signs	120	0	3	2.48	0.788
Insufficient nursing staffing and inadequate rotational rest schedules	120	0	3	2.45	0.858
Shortages of supplies, equipment and surgical instruments intraoperatively	120	0	3	2.44	0.786
Valid cases per column	120				

Table 3: Ranking of the top five contributing factors for missed nursing care by mean score.

Multiple Linear Regression Analysis of Influencing Factors

Multiple linear regression analysis (Enter method) was performed with total missed nursing care score as the dependent variable, and average daily surgical volume, weekly working hours and overtime frequency as independent variables (Table 4).

Coefficients[a]								
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearity Statistics	
		B	Std.Error	Beta			Tolerance	VIF
1	(Constant)	-25.499	8.225		-3.1	0.002		
	Average Daily Surgical Volume	5.873	2.8	0.172	2.098	0.038	0.959	1.042
	Working Hours	9.011	2.929	0.253	3.076	0.003	0.955	1.047
	Overtime Frequency	6.205	1.678	0.308	3.697	0	0.933	1.071
Note: R^2=0.249, Adjusted R^2=0.230, F=12.818, P<0.001.								

Table 4: Multiple linear regression analysis of factors influencing missed nursing care among operating room nurses (n=120).

The regression model achieved high statistical significance ($F=12.818$, $P<0.001$), with an adjusted R^2 of 0.230, indicating the three predictors collectively explained 23.0% of the total variance in missed nursing care scores. Collinearity diagnostics showed VIF values ranging from 1.042 to 1.071, all far below the critical threshold of 10, confirming the absence of multicollinearity among independent variables.

Overtime frequency ($\beta=0.308$, $P<0.001$), weekly working hours ($\beta=0.253$, $P=0.003$), and average daily surgical volume ($\beta=0.172$, $P=0.038$) were all independent predictors of missed nursing care. Overtime frequency exerted the strongest predictive effect; nurses with frequent overtime demonstrated significantly higher missed care scores than those without overtime. Longer weekly working hours and higher daily surgical volume were both associated with greater severity of missed nursing care.

Discussion

Overall Risk of Missed Care Is Controllable; Intraoperative Phase Is the Core Weak Link for Perioperative Safety Control

Perioperative nursing consists of three sequential phases: preoperative preparation, intraoperative support, and postoperative care. The completeness of nursing interventions in each phase directly impacts patient safety and postoperative recovery [11]. The present survey yielded a total missed care score of (20.75±17.56) and an average item score of only (0.74±0.63) (full score = 4), indicating an overall low frequency of occasional omissions and generally sound compliance with fundamental nursing protocols in regional operating rooms [12]. This favourable outcome can be attributed to the sample composition, where 66.7% of participants worked in tertiary hospitals. Such institutions maintain sophisticated quality control frameworks, standardized operating procedures and routine supervision systems that systematically limit routine nursing oversights and elevate baseline adherence to care standards [13].

Risk of missed nursing care varied markedly across perioperative stages: the intraoperative subscale score (9.79±8.21) was substantially higher than the postoperative score (2.13±2.27). Intraoperative nursing involves high-stakes responsibilities including sterile field management, instrument counts, surgical specimen handling, and continuous vital sign monitoring. Surgical workflows are unpredictable and frequently interrupted by emergency events [14]; the high-pressure, fast-paced environment readily causes skipped nursing steps and incomplete workflows. In contrast, postoperative tasks are largely standardized processes such as specimen delivery and patient handover, with clear operational boundaries and fewer unexpected variables, resulting in lower rates of omissions and errors [15].

Excessive Workload Acts as the Direct Predictor of Missed Nursing Care

Regression results verified that overtime frequency ($\beta=0.308$, $P<0.001$) served as the strongest predictor of missed nursing care. Nurses subjected to chronic overtime exhibited far more frequent care omissions than those following standard working schedules [16], consistent with international perioperative nursing research. Edfeldt et al. [17-19] similarly identified inadequate staffing as the primary contributor to missed nursing care.

Weekly working hours exerted a significant positive influence on missed care ($\beta=0.253$, $P=0.003$). Nearly 70% of participants worked 30–60 hours weekly, while 28.3% exceeded 60 hours per week, meaning over 30% of nurses endured persistent excessive workloads. Sustained long working hours compound physical exhaustion and emotional burnout, diminishing reaction speed and sustained attention, which substantially increases recurrent nursing omissions [6].

Average daily surgical volume constituted another independent risk factor ($\beta=0.172$, $P=0.038$); departments with higher surgical throughput reported more severe missed care. High-volume operating rooms face constant task compression, compounded by cumulative fatigue from chronic heavy workloads, forming a vicious cycle: high surgical volume → tight workflow pace → physical and mental exhaustion → increased missed nursing interventions, continuously exacerbating patient safety risks. Collectively, regression outputs demonstrate that workload represents a multifaceted risk construct integrating overtime frequency, total weekly working hours and departmental surgical throughput, and constitutes the dominant human factor driving missed perioperative nursing care.

Insufficient Staffing Is the Root Cause; Intraoperative Unexpected Changes Trigger Acute Missed Care

Subjective scoring of missed care triggers identified the top three contributing factors: “unexpected intraoperative adjustments including modified or additional surgical procedures” (2.54±0.72), “heavy surgical volume with numerous critically ill patients” (2.49±0.71), and “sudden patient emergencies with unstable vital signs” (2.48±0.79). These three factors demonstrate clear hierarchical and interactive relationships. “Heavy surgical volume with critically ill patients” represents chronic background workload stress. A systematic review by Griffiths et al. [20] confirmed a significant correlation between understaffing and elevated rates of missed nursing care. “Sudden patient crises with unstable vital signs” constitute acute stressors. Rahmani et al. [21] demonstrated that managing intraoperative emergencies demands rapid cognitive prioritization from nurses, which systematically delays or cancels

routine nursing tasks. Intraoperative procedural modifications directly disrupt pre-established care plans and act as immediate triggers for missed interventions. Collectively, the three factors operate across distinct temporal dimensions (chronic vs. acute), action pathways (cumulative fatigue vs. situational disruption), and mechanistic modes (resource dilution vs. workflow breakdown), forming a sequential causal chain: chronic workload overload → acute emergency stress → breakdown of scheduled care plans → missed nursing interventions.

These findings reveal the underlying mechanism of perioperative missed care: such omissions rarely stem from isolated causes but arise from systemic instability triggered by the overlap of chronic fatigue and acute intraoperative disruptions [22].

Refined Operating Room Management Strategies Derived From Study Findings

Practical management recommendations are proposed across four dimensions: root-cause governance, in-process intervention, targeted high-risk department supervision, and phase-specific quality control.

- Dynamic human resource allocation based on surgical workload metrics Staffing levels should be differentiated according to each department's average daily surgical volume, procedural complexity and emergency case proportion, supplemented by floating backup staff during peak hours and flexible shift scheduling, while guaranteeing nurses' statutory rest entitlements. Evidence confirms flexible rosters reduce overtime burden, improve nurses' occupational wellbeing and enhance perioperative patient safety, delivering mutual benefits for clinical staff and patients [23].

- Establish routine fatigue monitoring and proactive intervention systems Nurses with consecutive overtime or excessive weekly working hours should be flagged under a fatigue early warning protocol, with temporary reassignment or short rest breaks deployed to halt cumulative burnout. Monthly total working hours should be incorporated into routine departmental nursing quality indicators, shifting fatigue management from retrospective accountability to prospective risk prevention. Barker et al. [24] identified strong correlations between workplace conditions and nurse fatigue; targeted workplace optimization effectively mitigates exhaustion and medical error rates.

- Tiered intensive supervision for high-workload operating rooms Units with excessive surgical throughput and frequent overtime should be designated priority nursing safety zones. Auxiliary support staff can be recruited to undertake non-clinical tasks including supply organization and environmental disinfection to reduce administrative burdens on registered nurses. Restructuring preoperative preparation and postoperative cleanup workflows allows perioperative nurses to concentrate on core clinical interventions, mitigating workload pressure at its source.

- Standardized full-cycle quality control targeting intraoperative vulnerable links Layered surgical checklists covering all intraoperative phases and mandatory dual-nurse verification for high-risk procedures should be implemented to address the high prevalence of intraoperative missed care. On-site quality rounds enable real-time monitoring of nursing practice, with standardized workflows minimizing human error and strengthening intraoperative safety governance. Gillespie et al. [25] reported that missed perioperative care most frequently occurs in communication, documentation and patient monitoring; standardized protocols targeting these domains significantly reduce care omissions.

Study Limitations and Future Perspectives

This study has several limitations: **(1)** A convenience sampling method was adopted with a limited sampling frame, restricting the generalizability of findings; **(2)** The cross-sectional study design prohibits causal inference; **(3)** All data relied on nurses' self-reporting, which may introduce social desirability bias and recall bias. Future multi-center, large-sample longitudinal studies are recommended to further elucidate causal mechanisms of missed nursing care and evaluate the efficacy of targeted interventions.

Conclusion

Overall missed nursing care among operating room nurses remained at a low level, yet the intraoperative phase constituted the primary high-risk stage for care omissions. Overtime frequency represented the strongest predictor of missed nursing care, followed by weekly working hours and average daily surgical volume. Understaffing and collective nurse fatigue act as major contributing factors. Nursing administrators must optimize human resource allocation, rationalize working schedules, and prioritize quality oversight in high-workload departments. Systematic, multifaceted interventions are required to reduce missed nursing care and safeguard surgical patient safety.

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