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ORIGINAL ARTICLE

The effect of missed care on the nursing image perceived by patients and their trust relationships with nurses

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Abstract

Background: Missed care has negative consequences for patients, directly affecting the quality of nursing care and patient safety.

Aim: This study investigated the effect of missed care on the nursing image perceived by patients and their trust relationships with nurses.

Methods: This descriptive and correlational study was conducted in all inpatient wards of a hospital in southern Türkiye. The sample consisted of 200 patients. Data were collected using a patient information form, the MISSCARE Survey-Patient, the Nursing Image Scale (NIS), and the Trust in Nurses Scale (TNS). The data were analyzed using the Statistical Package for Social Sciences (for Windows 25.0). The study adhered to the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines.

Findings: Participants had a mean MISSCARE Survey-Patient, TNS, and NIS score of 2.09 ± 0.53, 23.48 ± 5.01, and 71.52 ± 6.75, respectively. There was a moderate negative correlation between MISSCARE Survey-Patient and TNS scores. There was a weak negative correlation between MISSCARE Survey-Patient and NIS scores. Moreover, there was a strong positive correlation between NIS and TNS scores.

Discussion: MISSCARE Survey-Patient total scores vary due to the imbalance in the number of nurses and the complexity of their tasks. Poor quality of care and incomplete care undermine the image of nursing and negatively affect the trust relationship between patients and nurses.

Conclusions: Nursing image and trust in nurses decreases as patient–nurse communication and basic care interventions are skipped.

Implications for nursing policy: Inadequate care can have a detrimental effect on the nursing image and erode patient–nurse trust relationships. Therefore, there is a pressing need for ongoing review and enhancement of nursing education, policy, and practice to elevate the quality of care provided. Further research utilizing objective staff measures and outcome assessments, along with gathering primary data directly from patients, is essential to substantiate the assertion that missed care significantly influences patient outcomes.

KEYWORDS
care, missed care, nursing, nursing care, nursing image, trust in nursing

INTRODUCTION

Missed nursing care is when nurses miss or delay some or all the planned care interventions that patients need (Bayram et al., 2023). When nursing care is missed, it falls under the category of an error of omission. This type of error signifies the failure to execute the appropriate intervention or treatment that should have been provided to the patient. This

concept directly affects the quality of nursing care, patient safety, and patient outcomes (Sönmez et al., 2020). Missed nursing care occurs due to inadequate staffing levels, deficient organizational communication (Andersson et al., 2022; He et al., 2022; Pan & Lin, 2022), and constrained financial resources (Safdari et al., 2023). Additionally, incidents of verbal violence, such as humiliation, shouting, and threats, are also regarded as contributing factors (Bayram et al., 2023). Research shows that the most common missed nursing care interventions are basic care interventions (ambulation, change of position, nutrition, hygiene, and medication at the right time), followed by participation in interdisciplinary case meetings, discharge planning, and patient education about diseases and discharge (Papathanasiou et al., 2024; Silva-Ramos et al., 2021; Willis & Brady, 2022). Al-Ghraiybah et al. (2024) reported that each additional patient per nurse in inpatient wards was associated with an increase in missed care.

Zeleníková et al. (2020) conducted research in four European countries and found that almost all nurses missed one or more care steps (95.2% to 97.8%). Most nurses report at least one unfinished task per shift. Researchers emphasize that missed nursing care is an international problem (Gustafsson et al., 2020). Missed nursing care is high in the USA and other countries (AHRQ, 2019). Missing nursing care is a warning sign of poor patient outcomes (Gülçek, 2022). Earlier research has shown that missed nursing care has negative consequences for patients (Janatolmakan & Khatony, 2022; Labrague et al., 2020), such as dissatisfaction, falls, pressure ulcers, and infections (Safdari et al., 2023). Min et al. (2020) reported a positive correlation between missed care and medication errors. They also found that nurses taking longer breaks were more likely to miss care steps. Chang and Manojlovich (2023) determined that nurses with high patient safety competence missed fewer care steps. Patients are good observers of missed nursing care and can provide information about problems that health professionals cannot clearly see (Kendir et al., 2023). Research shows that nurses miss basic care steps due to staff shortages (İspir et al., 2024; Gustafsson et al., 2020). Therefore, patients have more difficulty communicating with nurses, have to wait for help, are less satisfied with the care they receive, and experience problems such as time problems (Gustafsson et al., 2020).

Purpose

While researchers have pointed out that missed nursing care has negative consequences for patients, no researchers have investigated the effect of missed care on the nursing image perceived by patients and their trust relationships with nurses. Therefore, this study investigated what patients thought about missed nursing care and examined the impact of missed care on the nursing image perceived by patients and their trust relationships with nurses. The following research hypotheses have been considered:

H1: Missed care adversely impacts the nursing image perceived by patients.

H2: Missed care adversely impacts patients' trust in nurses.

METHODS

Research design and participants

This descriptive and correlational study was conducted in all inpatient wards of a hospital in southern Türkiye. A power analysis (G. Power-3.1.9.2) was performed to calculate the sample size. The results showed that a sample of 138 would be large enough to detect significant differences (95% confidence level, $\alpha = 0.05$ margin of error, and 0.5123740 effect size) (Cohen, 1998; Faul et al., 2009). The study population consisted of 234 adult patients admitted to the inpatient wards between August 15 and November 15, 2023. Thirty-four patients were excluded because they declined to participate ($n = 13$), had communication problems ($n = 15$), or were illiterate ($n = 6$). Therefore, the sample comprised 200 participants.

Inclusion criteria

The inclusion criteria were as follows: (1) staying in the hospital for at least two nights, (2) being over 18 years of age, (3) volunteering, (4) reading and writing in Turkish, and (5) not having mental illness or any illness that would complicate communication.

Instrument

Demographic items

Demographic items were collected in accordance with previous studies (Kalisch and Xie, 2014; Alfuqaha et al., 2023). The demographic items included age, gender, education, marital status, having received nursing care before, previous hospitalization, and current treatment duration.

MISSCARE Survey-Patient

The MISSCARE Survey-Patient was developed by Kalisch and Xie (2014). It assesses whether proper nursing care is provided based on patient reports. The survey consists of 13 items and 3 subscales based on patient reports. The subscale "communication" consists of five items rated on a 5-point Likert-type scale ("1 = Never" to "5 = Always"). This subscale encompasses questions concerning various aspects of patient–nurse interactions and communication, focusing on the frequency and quality of communication regarding examinations,

treatments, care, rest, and opinions sought by the patient. The subscale "timeliness" consists of four items rated on a five-point Likert-type scale ("1 = less than 5 min" to "5 = more than 30 min"). This subscale comprises questions regarding the duration it took for nurses to respond to the patient's request for assistance with using the restroom or to attend to machine and call signals. The subscale "basic care" consists of four items rated on a 5-point Likert-type scale ("1 = Never" to "5 = Always"). This subscale comprises questions regarding basic needs such as bathing, oral care, and moving from bed to chair. The items in the communication and basic care subscales are reverse-scored. The total score of the 13 items indicates the total score of missed care. Higher scores indicate more missed care (i.e., poor quality care). The original survey has a Cronbach's alpha score of 0.83 (Kalisch &, Xie, 2014). The survey was adapted to Turkish by Sönmez et al. (2020) and has a Cronbach's alpha score of 0.78 (Sönmez et al., 2020).

Nursing Image Scale (NIS)

The NIS was developed by Cinar and Demir (2009). It is employed to determine how people perceive the nursing profession. It consists of 28 items and three subscales: (1) general appearance, (2) communication, and (3) occupational and educational characteristics. The items are rated on a three-point Likert-type scale ("1 = I agree," "2 = I partially agree," and "3 = I do not agree"). The total score ranges from 28 to 84, with higher scores indicating a better image of the nursing profession. The scale has a Cronbach's alpha score of 0.81 (Cinar & Demir, 2009).

Trust in Nurses Scale (TNS)

The TNS was developed by Radwin and Cabral (2010). The scale consists of five items, each intended to assess a nursing activity or understand patient feelings. The total score is the sum of the scores of all items. The total score ranges from 5 to 30, with higher scores indicating stronger trust in nurses. The scale was adapted to Turkish by Yücel and Ay (2013). The Turkish version consists of five items rated on a 6-point Likert-type scale [never (1), rarely (2), sometimes (3), frequently (4), usually (5), always (6)]. The Turkish version has a Cronbach's alpha score of 0.95 (Radwin & Cabral, 2010; Yücel & Ay, 2013).

Data collection

The data were collected between August 15 and November 15, 2023. The researchers briefed all patients on the research purpose and procedure. They also told them they could withdraw from the study anytime. They collected the data through face-to-face interviews, each lasting about 20 min. They stored the surveys in a locked cabinet in a safe place. They stored the data in a computer memory system with encryption protection that was only accessible to them. They assigned a code to each survey for confidentiality and anonymity.

Ethical considerations

The study was approved by Toros University Scientific Research and Publication ethics board (Date: 25/03/2022 & No: 35). Permission was obtained from the Mersin Toros State Hospital (Date: 02/08/2023 and No: 46). Informed consent was obtained from all the participants. Each research stage was carried out according to the ethical principles of the World Medical Association's Declaration of Helsinki.

Data management and analysis

The data were analyzed using the Statistical Package for Social Sciences (Windows v. 25.0) at a significance level of 0.05. Means and standard deviations were used for continuous variables, while frequencies and percentages were used for categorical variables. Normality was tested using the Kolmogorov–Smirnov test. The independent sample *t*-test was used to compare two groups, while the one-way analysis of variance (ANOVA) was used to compare more than two groups. The Bonferroni correction was used for post-hoc comparisons. Significant data were evaluated using multiple regression analysis. Variables with significant differences were tested in the model. Pearson's correlation coefficient was used to determine the relationship between scale scores. There are no missing data.

RESULTS

Demographic characteristics

Table 1 lists the participants' demographic characteristics. Participants had a mean age of 50.53 ± 16.80 years. Less than half of the participants were literate or had primary school degrees (47%). Over half of the participants had received nursing care before (73.5%). Less than half of the participants had been hospitalized once or twice before (40%). Half of them were treated for 1–4 days (50.5%) (Table 1).

Scale score

Participants had a mean MISSCARE Survey-Patient score of 2.09 ± 0.53. They had mean MISSCARE Survey-Patient "communication," "basic care," and "timeliness" subscale scores of 3.51 ± 1.17, 2.16 ± 0.78, and 0.58 ± 0.63, respectively. They had mean NIS and TNS scores of 71.52 ± 6.75 and 23.48 ± 5.01, respectively (Table 2).

TABLE 1 Demographic characteristics.

	n	%
Age (x̄:50.53 ± 16.80)		
18–39	64	32.0
40–59	74	37.0
>60	62	31.0
Gender		
Woman	96	48.0
Man	104	52.0
Education (degree)		
Primary school/middle school	94	47.0
High school	54	27.0
Bachelor's or higher	52	26.0
Marital status		
Single	49	24.5
Married	151	75.5
Have you ever received nursing care before?		
Yes	147	73.5
No	53	26.5
How many times have you been hospitalized before?		
0	48	24.0
1–2	80	40.0
≥3	72	36.0
Treatment duration (day)		
1–4	101	50.5
≥5	99	49.5

The distribution of scale scores by sample characteristics

Table 2 summarizes the distribution of scale scores by sample characteristics. Married participants had a significantly higher mean MISSCARE Survey-Patient "basic care" subscale score than their single counterparts ($p < 0.05$). Participants who had received nursing care before had a significantly higher mean MISSCARE Survey-Patient "timeliness" subscale score than those who had not ($p < 0.05$). Participants who were treated for 1–4 days had a significantly higher mean MISSCARE Survey-Patient total and "communication" subscale score than those who were treated for more than four days ($p < 0.05$). Participants older than 59 had a significantly higher mean NIS score than those between the ages of 18 and 39 ($p < 0.05$). Literate participants and those with primary school degrees had a significantly higher mean NIS score than others ($p < 0.05$) (Table 2).

Predicators of MISSCARE Survey-Patient, NIS and TNS

Independent variables (treatment duration, NIS, and TNS) that affected MISSCARE Survey-Patient scores were evaluated using multiple regression analysis. Table 3 shows that the treatment durations and TNS scores significantly affected MISSCARE Survey-Patient scores (R^2= 0.197; $F = 17.281$; $p = 0.000$). The regression coefficients indicated that (B) the longer the treatment, the higher the MISSCARE Survey-Patient scores ($\beta = 0.161$; $p < 0.05$). The regression coefficients also indicated that (B) the higher the TNS scores, the lower the MISSCARE Survey-Patient scores (β = -0.591; $p = 0.000$).

Independent variables (education and TNS) that had an effect on NIS scores were evaluated using multiple regression analysis. The results showed that education levels and TNS scores significantly affected NIS scores (R^2= 0.440; $F = 20.547$; $p = 0.000$). The regression coefficients indicated that (B) the lower the education level, the higher the NIS scores ($\beta = -2.300$; $p < 0.005$). The regression coefficients also indicated that (B) the higher the TNS scores, the higher the NIS scores ($\beta = 0.850$; $p < 0.005$) (Table 3).

Independent variables (MISSCARE Survey-Patient "communication," "basic care," and "timeliness" subscale scores and NIS scores) that had an effect on TNS scores were evaluated using multiple regression analysis. Table 3 shows that the MISSCARE Survey-Patient"communication" and "basic care" subscale scores significantly affected TNS and NIS scores (R^2= 0.440; $F = 51.528$; $p = 0.000$). The regression coefficients indicated that (*B*) the higher the TNS scores, the lower the MISSCARE Survey-Patient "communication" ($\beta = -0.304$; $p = 0.000$) and "basic care" subscale scores ($\beta = -0.150$; $p < 0.005$) (Table 3).

The relationship between MISSCARE Survey-Patient, NIS, and TNS score

Table 4 reveals a moderate negative correlation between MISSCARE Survey-Patient total score and TNS scores (r: −0.428; $p < 0.01$). There was a weak negative correlation between "communication" subscale scores and TNS scores (r: −0.395; $p < 0.01$). There was a weak negative correlation between the MISSCARE Survey-Patient total score and NIS scores (r: −0.260; $p < 0.01$). There was a very weak negative correlation between "communication" subscale scores and NIS scores (r: −0.199; $p < 0.01$). There was a weak negative correlation between "basic care" subscale scores and NIS scores (r: −0.215; $p < 0.01$). There was a weak negative correlation between MISSCARE "basic care" subscale scores and TNS scores (r: −0.362; $p < 0.01$). Moreover, there was a strong positive correlation between NIS scores and TNS scores (r: 0.642; $p < 0.01$) (Table 4).

DISCUSSION

Most studies that have reported adverse impacts of missed nursing care on patients have collected data from nurses (Labrague et al., 2020; Recio-Saucedo et al., 2018; Sarpong et al., 2023). However, this study collected primary data from patients.

TABLE 2 The distribution of scale scores by sample characteristics ($n = 200$).

	MISSCARE Survey-Patient					
	Total Scale ($\bar{x}$: 2.09 ± 0.53)	**Basic care ($\bar{x}$: 2.16 ± 0.78)**	**Communication ($\bar{x}$: 3.51 ± 1.17)**	**Timeliness ($\bar{x}$: 0.58 ± 0.63)**	**NIS ($\bar{x}$: 71.52 ± 6.75)**	**TNS ($\bar{x}$: 23.48 ± 5.01)**
	$\bar{X} \pm SD$	$\bar{X} \pm SD$	$\bar{X} \pm SD$	$\bar{X} \pm SD$	$\bar{X} \pm SD$	$\bar{X} \pm SD$
Age[b]						
18–39[1]	2.07 ± 0.51	3.63 ± 1.08	2 ± 0.66	0.6 ± 0.65	69.94 ± 7.42	22.77 ± 4.59
40–59	2.08 ± 0.53	3.48 ± 1.13	2.21 ± 0.8	0.52 ± 0.59	71.42 ± 6.35	23.8 ± 4.3
>60[3]	2.12 ± 0.56	3.41 ± 1.32	2.26 ± 0.85	0.64 ± 0.66	73.26 ± 6.16	23.84 ± 6.09
p	0.885	0.127	0.558	0.561	**0.021 (3 > 1)**	0.385
Gender[a]						
Woman	2.06 ± 0.52	3.42 ± 1.26	2.11 ± 0.78	0.65 ± 0.64	71.67 ± 6.93	23.53 ± 5.23
Man	2.12 ± 0.54	3.59 ± 1.09	2.2 ± 0.78	0.53 ± 0.62	71.38 ± 6.61	23.43 ± 4.81
p	0.475	0.396	0.288	0.182	0.761	0.890
Education (degree)[b]						
Primary school	2.08 ± 0.56	3.34 ± 1.29	2.23 ± 0.82	0.63 ± 0.65	73.69 ± 5.81	24.37 ± 4.93
Middle school[1]	2.12 ± 0.43	3.74 ± 1.01	2.18 ± 0.7	0.44 ± 0.53	70.2 ± 6.84	22.93 ± 5.07
High school[2]	2.07 ± 0.57	3.57 ± 1.1	2.01 ± 0.75	0.66 ± 0.68	68.94 ± 7.1	22.44 ± 4.88
Bachelor's or higher[3]						
p	0.855	0.247	0.128	0.124	**0.000 (1 > 2.3)**	0.052
Marital status[a]						
Single	2.1 ± 0.53	3.52 ± 1.2	2.23 ± 0.8	0.54 ± 0.61	70.29 ± 7.47	23.57 ± 4.32
Married	2.04 ± 0.52	3.48 ± 1.09	1.95 ± 0.64	0.73 ± 0.68	71.91 ± 6.48	23.45 ± 5.22
p	0.488	**0.027**	0.842	0.063	0.143	0.883
Have you ever received nursing care before?[a]						
Yes	2.1 ± 0.54	3.43 ± 1.22	2.19 ± 0.79	0.64 ± 0.62	71.71 ± 6.87	23.46 ± 5.37
No	2.07 ± 0.52	3.72 ± 1.01	2.06 ± 0.73	0.42 ± 0.65	70.96 ± 6.44	23.53 ± 3.89
p	0.750	0.300	0.124	**0.032**	0.488	0.935
How many times have you been hospitalized before?[b]						
0	2.04 ± 0.5	3.65 ± 1	2.04 ± 0.68	0.44 ± 0.67	70.88 ± 6.71	23.67 ± 3.94
1–2	2.13 ± 0.57	3.61 ± 1.1	2.17 ± 0.82	0.59 ± 0.62	71.94 ± 6.12	23.6 ± 4.32
≥3	2.08 ± 0.51	3.3 ± 1.34	2.23 ± 0.79	0.67 ± 0.61	71.47 ± 7.48	23.22 ± 6.25
p	0.665	0.435	0.163	0.139	0.690	0.860
Treatment duration (day)[a]						
1–4	2.2 ± 0.48	3.69 ± 1.19	2.23 ± 0.69	0.66 ± 0.64	70.94 ± 6.6	22.95 ± 4.93
≥5	1.98 ± 0.56	3.33 ± 1.14	2.08 ± 0.85	0.51 ± 0.61	72.1 ± 6.88	24.02 ± 5.05
p	**0.004**	0.170	**0.029**	0.091	0.225	0.131

[a]Independent sample *t*-test.
[b]One-way ANOVA test.

Our participants had higher MISSCARE Survey-Patient scores than were reported by most previous studies (İspir Demir et al., 2024; Sönmez et al., 2020). However, Yayla et al. (2023) reported higher MISSCARE scores than our participants. Our results may be due to the insufficient number of nurses and task complexity. Earlier research has shown a positive correlation between missed care and staff shortages (Andersson et al., 2022; Zeleníková et al., 2020). In our study, the inadequacy in the number of nurses working in Turkey, the imbalance in the distribution of duties, and the task complexity of nurses in health institutions (Ün et al., 2023) may have caused care to be missed. As we know, better nurse staffing is associated with fewer missed care activities (Gülçek, 2022; Duhalde et al., 2023). Longitudinal and experimental research is needed to better explain the effects of missed care on adverse patient outcomes.

TABLE 3 Predicators of MISSCARE Survey-Patient, NIS, and TNS ($n = 200$).

	Dependent variable: MISSCARE Survey-Patient total				
Independent variables	***ß***	***B***	**95% CI**	***t***	***p***
Constant	39.931	–	30.460/49.401	8.315	**0.000***
Treatment duration = 1–4 days (*R*)					
Treatment duration = ≥5 days	−2.211	−0.161	−3.940/−0.481	−2.520	**0.013***
NIS	0.031	0.030	−0.136/0.197	0.365	0.715
TNS	−0.591	−0.430	−0.816/−0.366	−5.182	**0.000***
		R: 0.457	R^2: 0.197	*F*: 17.281	*p*: 0.000*
	Dependent variable: NIS				
Independent variables	***ß***	***B***	**95% CI**	***t***	***p***
Constant	53.190		46.868/59.512	16.596	**0.000***
Age = 18–39 (*R*)					
Age = 40–59	−0.637	−0.046	−2.558/1.283	−0.655	0.513
Age = >60	0.003	0.000	−2.457/2.463	0.002	0.998
Education = literate/primary school (R)					
Education = high school	−2.300	−0.152	−4.371/−0.228	−2.189	**0.030***
Education = bachelor's or higher	−3.058	−0.199	−5.4/−0.715	−2.575	**0.011***
MISSCARE Survey-Patient communication	0.056	0.032	−0.155/0.267	0.521	0.603
MISSCARE Survey-Patient basic care	−0.004	−0.003	−0.181/0.173	−0.045	0.964
MISSCARE Survey-Patient timeliness	−0.230	−0.086	−0.533/0.074	−1.493	0.137
TNS	0.850	0.631	0.687/1.014	10.270	**0.000***
		R:0.680	R^2:0.440	F:20.547	p:0.000*
	Dependent variable: TNS				
Independent variables	***ß***	***B***	**95% CI**	***t***	***p***
Constant	−1.385		−7.655/4.885	−0.436	0.664
MISSCARE Survey-Patient communication	−0.304	−0.236	−0.441/−0.167	−4.384	**0.000***
MISSCARE Survey-Patient basic care	−0.150	−0.141	−0.271/−0.029	−2.444	**0.015***
MISSCARE Survey-Patient timeliness	0.131	0.066	−0.078/0.341	1.235	0.218
NIS	0.419	0.565	0.343/0.494	10.913	**0.000***
		R: 0.717	R^2: 0.504	*F*: 51.528	*p*: 0.000*

*$p < 0.05$, **$p < 0.01$, *B*: Regression coefficient, *F*: Analysis of variance, *ß* (standardized beta): Partial regression coefficient, *T*: Internal significance test of regression coefficients, *R*: Level of association, R^2: Coefficient of determination, CI: Confidence interval.

Our results indicated that missed nursing care was in the communication, basic care, and timeliness sub-dimensions, respectively. Even in studies where the average MISSCARE Survey-Patient score was found to be lower than our results, it was reported that all sub-dimensions of nursing care were perceived inadequately by patients (Gustafsson et al., 2020; Sönmez et al., 2020). Zeleníková et al. (2020) found that nurses had difficulty communicating with patients and their family members and responding to patient requests in a timely manner. Chaboyer et al. (2021) reported that the majority of unmet nursing care needs reported by patients were communication, self-management, autonomy, education, and emotional and psychological care. As it is known, communication with the patient is one of the most basic nursing interventions. Patients perceive its deficiency when nurses fail to communicate with them effectively. Our results pointed to missed care activities in terms of patient–nurse communication, basic care, and timeliness, which may be due to insufficient staff and a high workload. Our participants reported missing basic care, which suggests that basic care interventions (such as bathing, oral care, moving from bed to chair, standing) are considered very important by patients.

Our participants had a lower mean NIS score than what has been reported by earlier studies (Karakaplan & Ulupınar, 2023; Topuz et al., 2023). This may be related to the rate of missed care reported by our participants because one of the most important factors affecting nursing image is the quality of care. Nurses and patients report that the care

TABLE 4 The relationship between MISSCARE Survey-Patient, NIS, and TNS score ($n = 200$).

	TNS		NIS	
	r	*p*	*r*	*p*
MISSCARE Survey-Patient total	−0.428**	**0.000**	−0.260**	0.000
MISSCARE Survey-Patient communication	−0.395**	**0.000**	−0.199**	0.005
MISSCARE Survey-Patient basic care	−0.362**	**0.000**	−0.215**	0.002
MISSCARE Survey-Patient timeliness	0.115	0.106	−0.002	0.982
NIS	0.642**	**0.001**	**1**	–

Pearson's correlation test.

provided or received is incomplete when staffing is inadequate (Recio-Saucedo et al., 2018; Sönmez et al., 2020).

Our participants had a similar TNS score than reported by earlier studies (Ahmadpour et al., 2020; Coskun Palaz & Kayacan, 2023; Ozaras & Abaan, 2018). Establishing trust with patients is one of the main goals of care. Gallup (2023) found that nursing was ranked first in terms of professional honesty. The public's perception of nursing as trustworthy also positively affects its image. Our participants scored the highest on the TNS item "being there for patients in their time of need." This result shows the importance of nurses being there for patients and that the presence of nurses is an important factor contributing to the nurse–patient trust relationship. Previous studies show that nurse presence is associated with positive patient outcomes (Canbolat et al., 2024). When patients do not interact with nurses, they are more aggressive towards staff and experience loneliness and anxiety (Bayram et al., 2023).

Our results showed that the longer the treatment, the lower the MISSCARE Survey-Patient score. No researchers have investigated the relationship between missed nursing care and hospital stay. However, earlier research has not detected a significant relationship between hospital stay and patient experiences (Dığın et al., 2022; Topuz et al., 2023). On the other hand, Edeer et al. (2020) found that patients who stayed in hospitals for a longer period had more negative experiences. Göktas et al. (2016) documented that patients who stayed in intensive care units (ICUs) for less than three days had more positive experiences than those who stayed in ICUs for three and four days. This is probably because nurses provide less patient care after the first few days of hospitalization.

Our results indicated that participants with higher education levels viewed the nursing profession in a more negative light. However, some studies did not report a relationship between patients' education and their trust in nurses (Coşkun Ahmadpour et al., 2020; Palaz & Kayacan, 2023). Our results suggest that highly educated patients expect more from nurses. The fact that patients' level of education and their sense of trust in nurses affected the nursing image they perceived emphasizes the fact that patient-centered care approaches rather than routine care are more important in terms of quality of care.

Our results indicated a weak-moderate negative correlation between MISSCARE Survey-Patient "basic care" subscale scores and NIS and TNS scores, and between "communication" subscale scores and TNS scores. There is a study that finds a relationship between missed nursing care and communication (He et al., 2022). Nurses improve the quality of care by highlighting their communication skills and applying the art of nursing. Nurses who provide communication-centered care focus on the uniqueness of their patients and make them feel valued. Moreover, they are there for their patients and are sensitive to their subjective experiences (Kwame & Petrucka, 2021). Strengthening communication between nurses and patients can reduce uncertainty, increase patient participation in decision-making processes, increase compliance with medication and treatment plans, increase social support in care, and a sense of trust between the patient and nurse, and a positive nursing image (He et al., 2022). Consequently, effective communication between nurses and patients is crucial to improving patient-centered care and promoting positive care outcomes. Isik et al. (2023) reported that most people associate nurses with healers and that the public gives nursing a caring meaning. Inadequate and incomplete care tarnishes the image of nursing. These findings showed the impact of taking patients' individual needs into consideration in patient–nurse communication and basic care practices on the nursing image and feelings of trust in nurses. While no research has investigated the relationship between trust in nurses and missed care, it is reported that missed nursing care jeopardizes patient safety (Ilaslan & Yıldırım Şişman, 2019). Patients' trust in nurses directly influences the quality of their relationship. When trust diminishes, it can strain the connection and rapport between patients and nurses. If patients trust nurses, nurses are more likely to be able to identify their health problems completely and accurately. As the trust between patients and nurses grows stronger, patients often feel more comfortable and open to sharing additional information about their health status (Molina-Mula & Gallo-Estrada, 2020). Hospitals should pay attention to nurses' missed care reports and regard routine monitoring as a quality and safety indicator. In addition, nurse managers and health policymakers should provide support to nurses by being aware of the reasons for missed care.

Limitations

This study has four limitations. First, the results are sample-specific and cannot be generalized to all patients. Therefore, studies conducted in different countries and regions are needed to confirm the results. Second, we were unable to assess the extent of nursing interventions because nurses on different wards provide different interventions. Third, the data are based on what the patients reported and are quite subjective. Fourth, we did not evaluate whether there was a

shortage of nurses in the shifts. Researchers should conduct studies using different research methods regarding missed nursing care.

CONCLUSION

Missed nursing care has adverse effects on nurse–patient interaction. Patients with more missed care trust nurses less and view the nursing profession in a more negative light. In addition, patients who cannot communicate effectively with nurses and whose basic care needs are not met more often trust nurses less and have a more negative view of nursing. This loss of trust and negative image may negatively affect the quality of care. The nursing profession should move away from the biomedical model that does not consider human uniqueness and should include care that prioritizes patient needs, interaction, and communication. In this way, the prestige of the profession can be preserved. Therefore, nurses need to pay more attention to patients' care and communication needs. Moreover, nurses should consider the fact that each patient has different needs. Routine care may not satisfy every patient. Nurses should recognize the uniqueness of their patients, identify their needs, and provide care accordingly.

IMPLICATIONS FOR NURSING EDUCATION, PRACTICE, AND POLICY

Inadequate care has negative effects on the nursing image and patient–nurse trust relationships. Therefore, nursing education, policy, and practice must be continually reviewed and improved to enhance the quality of care. Reviewing measures (focusing more on basic care in nursing education and using different educational methods) may be useful in improving the quality of care. Nurse managers and health system managers should seek solutions regarding factors such as insufficient number of nurses and task complexity.

Obtaining objective staffing data and further research using outcome measures are important steps to verify the claim that missed care negatively impacts patient outcomes. Collecting such data through objective measures can provide concrete evidence of the correlation between missed care and its impact on patient outcomes. Therefore, hospitals should pay attention to nurses' reports of missed care and consider routine monitoring as an indicator of quality and safety. Thus, nurses can gain patient trust and strengthen the nursing image.

AUTHOR CONTRIBUTIONS

Behire SANCAR developed the study design, collected and analyzed the data, supervised the study, and provided critical revisions for important intellectual content. Ayse Buket DOGAN AKTAS developed the study design, collected and analyzed the data, wrote manuscript, and supervised the study.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

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