



Preventing Missed Basic and Supportive Care in Emergency Departments: Joint Roles of Nurses, Emergency Medical Technicians, and Health Care Assistants

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Abstract:

Preventing missed basic and supportive care (MBSC) in the overcrowded, high-pressure environment of the emergency department requires a fundamental shift from siloed practice to a model of deliberate, interprofessional collaboration. This approach strategically leverages the unique and complementary skills of the core frontline triad: the Registered Nurse (RN) as the holistic assessor, care coordinator, and patient advocate; the Emergency Medical Technician (EMT) as the technical expert managing procedures, monitoring, and logistics; and the Health Care Assistant (HCA) as the guardian of fundamental care and continuous presence, ensuring dignity, comfort, and hygiene. Effective prevention is achieved by moving beyond role ambiguity to establish clear, shared accountability through structured frameworks like TeamSTEPPS for communication, standardized care bundles for common needs, and interprofessional rounding. Sustainable implementation demands committed leadership to foster a culture that values this care as a critical safety indicator, alongside targeted interprofessional education, technological enablers, and rigorous measurement of MBSC itself. Ultimately, integrating the joint capabilities of RNs, EMTs, and HCAs builds a resilient defense against the omission of essential care, safeguarding patient outcomes, preserving dignity, and upholding the humane core of emergency medicine amidst chaos.

1. Introduction

The modern hospital Emergency Department (ED) stands as the critical frontier of acute healthcare, a high-stakes environment designed to triage, resuscitate, stabilize, and initiate treatment for a ceaseless influx of patients with conditions spanning from the mundane to the life-threatening. This mission, inherently focused on rapid diagnosis and intervention for acute pathologies, is executed under immense pressure characterized by crowding, unpredictable patient volumes, resource limitations, and the constant tension between efficiency and thoroughness. Within this tumultuous ecosystem, a silent epidemic often unfolds: the systematic omission of fundamental, non-technical aspects of patient care, collectively termed missed nursing care. However, this concept must be expansively reconsidered in the ED context as **missed basic and supportive care (MBSC)**, a phenomenon that extends beyond the purview of registered nurses alone to encompass the collective potential failures of the entire frontline clinical team, including Emergency Medical Technicians (EMTs) and Health Care Assistants (HCAs) [1]. Missed care is formally defined as any required patient care activity that is omitted or significantly delayed. While much of the foundational research has emerged from inpatient nursing studies, its translation to the emergency setting reveals a unique and potent variant. In the ED, missed care is not merely about delayed documentation or omitted turns; it frequently involves the failure to provide essential humanistic and physiological sustenance during the most vulnerable periods of a patient's healthcare journey. This encompasses a range of activities: failure to provide adequate analgesia, neglect of oral hygiene and nutrition, inadequate

assistance with toileting leading to dignity-compromising accidents, insufficient patient education and communication, and the lack of emotional support and reassurance for both patients and their distressed families [2]. The consequences of these omissions are profound and far-reaching. They directly contribute to preventable patient harm, including hospital-acquired infections (such as those linked to poor catheter care or mobility), pressure injuries, clinical deterioration from unmet hydration or comfort needs, and increased patient anxiety and dissatisfaction. Furthermore, MBSC erodes the moral resilience of healthcare providers, fostering feelings of guilt, burnout, and professional dissatisfaction, which in turn perpetuates a vicious cycle of declining care quality and staff attrition [3]. The etiology of MBSC in the ED is multifactorial, but it is fundamentally rooted in systemic and environmental constraints. Chronic and acute ED overcrowding is the primary driver, creating an environment where time is the scarcest commodity. When patient volume exceeds functional capacity, staff are forced into a perpetual state of task-oriented "firefighting," where cognitive bandwidth is monopolized by immediate life threats, leaving little room for the attentive, compassionate care that defines basic and supportive tasks [4]. This is compounded by severe staffing shortages, which are endemic in healthcare systems globally. Inadequate nurse-to-patient ratios, often far exceeding safe benchmarks, mean that even the most diligent clinician is physically incapable of addressing all care needs for all assigned patients. The role of EMTs and HCAs, therefore, becomes not just supportive but absolutely critical to bridging this care gap. However, the problem is further exacerbated by poor interprofessional communication, ambiguous

role delineation, and a traditional hierarchical culture that may undervalue the contributions of non-physician team members. When roles are unclear or when communication channels are inefficient, tasks fall through the cracks, and accountability becomes diffuse [5].

To combat MBSC effectively, a paradigm shift is required. It necessitates moving beyond viewing these tasks as the exclusive domain of nurses and towards a model of **shared, interprofessional accountability**. This article posits that the prevention of MBSC in the Emergency Department is achievable only through the deliberate integration, clear role definition, and collaborative synergy of its three core frontline clinical groups: Registered Nurses (RNs), Emergency Medical Technicians (EMTs), and Health Care Assistants (HCAs). Each brings a unique skill set and perspective to the patient's bedside. The RN, with their holistic assessment skills and clinical judgment, must act as the care coordinator and delegator. The EMT, trained in rapid assessment, technical procedures, and pre-hospital crisis management, excels in dynamic situations and can manage specific clinical and monitoring tasks. The HCA, often possessing deep expertise in fundamental care and spending prolonged time with patients, is the essential guardian of patient comfort, hygiene, and dignity [6]. Their roles are not sequential but parallel and overlapping, requiring constant negotiation and teamwork.

This integrated approach aligns with established frameworks for patient safety, such as the Systems Engineering Initiative for Patient Safety (SEIPS) model, which emphasizes that outcomes are the product of interactions between the work system (tools, tasks, environment, organization) and the people within it [7]. It also resonates with the principles of the American Heart Association's systems of care, which highlight the importance of seamless transitions and role clarity in time-sensitive emergencies [8].

2. The Landscape of Missed Basic and Supportive Care in the ED

The phenomenon of missed care, while a concern across healthcare, manifests with distinct characteristics in the high-velocity, high-acuity environment of the Emergency Department. Here, the concept of "basic" care expands beyond bathing and feeding to include time-sensitive and safety-critical interventions that are paradoxically often deemed "non-urgent" in the triage hierarchy. This creates a dangerous dichotomy where immediate physiological threats are addressed, often with technological sophistication, while foundational

human needs are deferred, sometimes indefinitely. The spectrum of MBSC is broad and impactful, touching every aspect of the patient experience. It includes failures in fundamental physiological monitoring, such as inconsistent re-assessment of pain scores after analgesic administration or inadequate monitoring of fluid intake and output in vulnerable patients. Mobility assistance is frequently neglected, leading to prolonged periods of immobilization on hard stretchers, which is a direct precursor to pressure ulcers, muscle deconditioning, and increased fall risk upon discharge [9]. Perhaps most profoundly, MBSC strikes at the core of patient dignity and psychological well-being. Assistance with elimination is a stark example; patients may be left to wait in distress, leading to incontinent episodes that are humiliating and increase skin breakdown risk. Oral care, a simple intervention proven to reduce the risk of aspiration pneumonia and improve comfort, is routinely overlooked. Nutritional and hydration needs are superseded by diagnostic tests, leaving patients who may have been nil-by-mouth for hours without adequate sustenance. Furthermore, the provision of clear, compassionate communication and emotional support is often sacrificed at the altar of efficiency. Patients and families, already experiencing high anxiety, are left in information vacuums, unaware of plan of care, wait times, or diagnostic results, which significantly diminishes their perception of care quality and trust in the provider team [10].

The drivers of this landscape are deeply embedded in the ED's operational design. The primary catalyst is **resource scarcity**, most critically expressed as insufficient staffing ratios. Evidence consistently shows a direct correlation between higher patient-to-nurse ratios and increased incidence of missed care, medication errors, and patient mortality [11]. In the ED, this ratio is not static but wildly fluctuates, creating periods where even the most basic surveillance becomes impossible. Coupled with this is the pervasive issue of **crowding and throughput pressure**. When the department's physical and operational capacity is overwhelmed, the focus narrows to moving patients through the system—a concept known as "door-to-disposition" time. In this pressurized pipeline, tasks perceived as non-essential to the immediate diagnostic or disposition decision are the first to be jettisoned. The environment itself, with its lack of privacy, constant noise, and bright lighting, is inherently un conducive to restorative care and can numb both patients and providers to the importance of comfort measures [12]. An often-overlooked but critical factor is the **clash of professional cultures and ambiguous scope of practice**. The RN's scope

is broad and encompasses both advanced technical skills and fundamental care, but in crisis situations, the former inevitably takes precedence. EMTs, particularly those working in-hospital (often called Emergency Department Technicians), possess a skill set focused on immediate technical interventions (e.g., splinting, phlebotomy, ECG acquisition) but may receive less formal training or feel less ownership over holistic comfort care. HCAs, while experts in fundamental care, may operate under rigid task lists and lack the authority or communication pathways to alert the team to emerging patient needs beyond their immediate remit. Without clear protocols, shared mental models, and a culture of mutual respect, these groups can operate in silos, allowing patient needs that fall between their defined roles to go unmet [13]. The consequence is a system perfectly designed to produce the outcomes it gets: high throughput for acute diagnoses, but at the cost of consistent, dignified, and comprehensive humane care.

3. The Indispensable Triad: Defining Core Roles and Responsibilities

Effective prevention of MBSC requires a move from vague expectations to explicitly defined, complementary roles for each member of the frontline triad. This clarity is the bedrock of accountability and effective teamwork.

4. Registered Nurses: The Coordinators, Assessors, and Advocates

The registered nurse in the ED serves as the central node in the care network for each patient. Their role in preventing MBSC is multifaceted, encompassing assessment, delegation, direct intervention, and advocacy. Crucially, the RN is responsible for the initial and ongoing holistic nursing assessment, which goes beyond the medical diagnosis to identify risks for falls, pressure injuries, nutritional deficits, and psychosocial distress. It is this assessment that proactively identifies which basic and supportive care needs are most urgent for the individual patient [14]. Based on this assessment, the RN must practice judicious and intelligent delegation. This involves assigning specific tasks to EMTs or HCAs (e.g., "Please assist Mr. Smith in room 4 to the bathroom and perform a skin check," or "Please obtain a repeat set of vital signs and a pain score for the patient in room 10") while retaining accountability for the overall outcome. Delegation is not abdication; it requires clear communication of the task, its context, and the parameters for reporting back. Furthermore, the RN

performs many high-priority basic care tasks themselves, particularly those linked to clinical judgment, such as pain management, complex wound care, and patient/family education regarding diagnosis and discharge instructions. Perhaps their most critical role is that of **patient advocate**. In a system pushing for efficiency, the RN must consciously act as a brake, ensuring that the patient's need for comfort, information, and dignity is voiced and integrated into the care plan. This may involve negotiating with physicians for timely analgesia, coordinating with ancillary services, or simply taking the time to sit and listen to a fearful patient. The RN's leadership in modeling the value of this care sets the cultural tone for the entire team [15].

5. Emergency Medical Technicians: The Technical Experts and Situational Managers

EMTs, whether operating in the pre-hospital field or within the hospital as ED Technicians, bring a unique and vital skill set to the department. Their training is rooted in rapid, systematic assessment (e.g., scene size-up, primary and secondary surveys) and the performance of discrete technical procedures under protocol. This makes them exceptionally valuable in managing specific aspects of basic and supportive care that have a technical or monitoring component [16]. Their responsibilities can be strategically aligned to prevent MBSC. For instance, they are ideally positioned to manage continuous vital sign monitoring, 12-lead ECG acquisition, point-of-care testing, and specimen collection. They can perform splinting, crutch walking training, and simple wound irrigation and dressing—tasks that, if delayed, cause significant patient discomfort. Beyond procedures, EMTs can play a pivotal role in patient logistics and mobility. Assisting with patient transfers, ambulation, and positioning not only prevents injury to other staff but also directly addresses the missed care items of immobility and skin integrity risk. Their comfort with dynamic situations also makes them key players in providing reassurance and clear, simple explanations to patients during procedures they are assisting with or performing. By taking ownership of these defined technical and logistical domains, EMTs free up RN cognitive and physical time, allowing nurses to focus on complex assessments, care coordination, and the most sensitive patient interactions [17].

6. Health Care Assistants / Nursing Assistants: The Guardians of Fundamental Care and Continuous Presence

If the RN is the architect and the EMT the engineer of patient care in the ED, the Health Care Assistant is the steadfast builder and caretaker. HCAs are the professionals most intimately involved with the provision of fundamental, hands-on care. Their role is the most direct antidote to MBSC, as their core mandate is the very set of tasks most likely to be missed [18]. Their responsibilities form the backbone of patient comfort and dignity: assisting with bathing, toileting, and incontinence care; ensuring oral hygiene; providing or setting up meals and assisting with feeding; conducting regular turns and repositioning for high-risk patients; and ensuring the patient's immediate environment is clean, safe, and comfortable.

The HCA's power lies in their **continuous presence**. While nurses and physicians flow in and out for assessments and interventions, the HCA often has more sustained contact. This positions them as a critical surveillance system. They are often the first to notice subtle changes—a patient becoming more withdrawn, early skin redness, difficulty swallowing, or increasing anxiety. Therefore, their role must include not just task completion but **structured observation and communication**. Empowering HCAs to formally report their findings (e.g., using a standardized early warning score or simply a structured hand-off to the RN) transforms them from task-doers into essential members of the monitoring team. Their insights into patient behavior, comfort, and family dynamics provide a richness of data unavailable elsewhere, making them indispensable partners in comprehensive care [19].

7. Frameworks for Effective Collaboration and Communication

For the triad of RN, EMT, and HCA to function cohesively in preventing MBSC, intentional structures for collaboration must replace ad-hoc interactions. Effective models are built on shared mental models, standardized communication, and deliberate teamwork practices.

A foundational framework is **Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS)**. Developed by the Agency for Healthcare Research and Quality (AHRQ), TeamSTEPPS provides a suite of tools perfectly suited to the ED environment. The **SBAR** (Situation-Background-Assessment-Recommendation) technique ensures concise, structured communication during handoffs or when reporting concerns, whether from an HCA to an RN or an EMT to a physician. **Briefs** at the start of a shift can be used to establish team goals, including

explicit focus on preventing specific missed care items (e.g., "Today, let's all be extra vigilant about pain reassessment and turning our high-risk patients"). **Huddles** during the shift allow for quick problem-solving and redistribution of resources in response to changing acuity. **Debriefs** after a challenging case can identify system failures that led to missed care, turning incidents into learning opportunities [20].

Beyond communication tools, operationalizing collaboration requires **care bundles for basic needs**. Inspired by the success of bundles for conditions like sepsis or ventilator-associated pneumonia, EDs can develop simple, standardized protocols for ubiquitous needs. A "Comfort and Dignity Bundle" for a patient expected to have a prolonged stay might include: 1) Scheduled pain assessment every 2 hours, 2) Assisted toileting offer every 3 hours, 3) Oral care every 4 hours, and 4) Repositioning every 2 hours. The bundle is not assigned to one profession but to the *team*. The RN initiates it during assessment, the HCA performs the scheduled oral care and repositioning, the EMT assists with toileting and can report pain during vital sign checks, and the RN synthesizes the information. This shared ownership dissolves silos [21].

Furthermore, the concept of **interprofessional rounding** is transformative. Instead of physicians rounding alone or with just the RN, dedicated team rounds involving the RN, EMT, and HCA for a specific pod or zone of patients create a forum for shared situational awareness. In a brief huddle, each member contributes: The RN provides the medical and nursing plan, the EMT reports on procedural needs or monitoring findings, and the HCA shares observations on comfort, intake, and mobility. This 60-second exchange ensures all team members are aligned on the priorities for each patient, including basic care goals, and identifies who is responsible for which elements. It validates the contributions of all and formalizes their interdependent roles [22].

8. Strategies for Systemic Implementation and Sustainability

Creating a culture that prevents MBSC requires more than goodwill; it demands systemic changes in leadership, education, physical design, and measurement.

Leadership and Cultural Transformation: ED leadership must champion the message that basic and supportive care is not optional or "soft" but is a core indicator of quality and safety. This involves allocating resources strategically, such as ensuring adequate HCA staffing ratios and protecting time for team huddles. Leaders must actively break

down hierarchical barriers, fostering psychological safety where an HCA feels empowered to voice a concern about a patient's skin to an RN or physician without fear of reprimand. Recognizing and rewarding collaborative behavior that upholds patient dignity is as important as celebrating a successful resuscitation [23].

Education and Interprofessional Training: Role clarity is best achieved through joint training. Simulation scenarios that include RNs, EMTs, and HCAs working together to manage a complex patient while also addressing their pain, toileting, and family communication needs are powerful. Such training builds mutual respect, clarifies scope, and practices communication tools like SBAR in a low-stakes environment. Education should also focus on the "why"—emphasizing the evidence linking missed basic care to hard outcomes like pressure ulcers, falls, and infections, thereby framing these tasks as critical to patient safety [24].

Environmental and Technological Enablers: The physical layout of the ED can either hinder or help. Ensuring easy access to supplies (linen, hygiene kits, nutritional supplements) at the point of care reduces time waste. Privacy curtains that actually close and functioning call lights are basic but essential. Technology can be a force multiplier. Electronic health records can be configured with **mandatory fields or prompts** for basic care documentation (e.g., pain reassessment, turning schedules, intake/output). Secure messaging apps for the care team can facilitate quick tasking and updates (e.g., an RN messaging an HCA: "Bed 5 is cleared for a bathroom assist now"). Tracking compliance with care bundles through the EHR provides data for quality improvement [25].

Measuring and Monitoring MBSC: "What gets measured gets managed." To combat MBSC, EDs must first measure it. This can be done through regular **patient experience surveys** with specific questions on comfort, communication, and assistance with needs. **Staff surveys**, like the MISSCARE survey adapted for the ED, can anonymously identify which care elements are most frequently missed and why [26]. Direct observation or **chart audits** for documentation of key activities (turning, oral care, pain reassessment) provide objective data. Presenting this data back to staff in quality improvement meetings makes the problem visible and engages the team in developing solutions, creating a continuous feedback loop for improvement [27].

9. Challenges and Future Directions

Despite the clear rationale, significant barriers to implementation exist. **Persistent staffing shortages** are the most formidable, as any model

depends on having sufficient personnel to allow for role differentiation and teamwork. **Professional resistance and turf protection** can arise, with some nurses viewing delegation as a loss of control or some EMTs seeking to expand their scope into more advanced practices while devaluing fundamental care tasks. **Reimbursement models** that prioritize procedural volume over holistic care quality do not incentivize health systems to invest in the staffing and training required for this model [28].

The future of preventing MBSC lies in innovation and continued research. Exploring **advanced role integration**, such training certain EMTs or HCAs in specific extended skills (e.g., dedicated pain management technicians or mobility coaches), could further optimize team function. **Predictive analytics** using ED data may help identify patients at highest risk for experiencing missed care (e.g., the elderly, those with dementia, those with long lengths of stay), allowing for proactive, targeted intervention from the triad [29]. Ultimately, a cultural shift within emergency medicine itself is needed, one that formally recognizes the provision of humane, comprehensive care—not just rapid diagnosis—as the ultimate measure of emergency care excellence. This requires advocacy from professional bodies to include metrics of patient experience and fundamental care in accreditation standards and public reporting [30].

10. Conclusion

The prevention of Missed Basic and Supportive Care in the Emergency Department is not a peripheral concern but a central imperative for patient safety, dignity, and the integrity of the healthcare profession. It cannot be achieved by any single discipline working in isolation under the current strains of the healthcare system. The solution lies in harnessing the collective and complementary strengths of the essential frontline triad: the Registered Nurse, the Emergency Medical Technician, and the Health Care Assistant. The RN, as coordinator and advocate; the EMT, as technical and logistical expert; and the HCA, as guardian of fundamental care and continuous presence, together form a resilient network capable of withstanding the pressures of the ED environment.

By adopting structured frameworks for collaboration like TeamSTEPS, implementing shared accountability models like care bundles, and fostering a culture of mutual respect and psychological safety, ED teams can transform their practice. This transformation must be supported by committed leadership, interprofessional education, smart environmental design, and a rigorous

approach to measuring what matters. The challenges of staffing and finance are real, but the cost of inaction—measured in human suffering, preventable complications, and provider burnout—is far greater. Embracing this joint responsibility model represents a profound commitment to the principle that even in the midst of chaos and crisis, the provision of competent, compassionate, and comprehensive care remains the non-negotiable cornerstone of emergency medicine. It ensures that in the race to save lives, we do not lose sight of the humanity of those we are striving to save.

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