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Missed Nursing Care and Its Impact on Early Recognition of Clinical Deterioration: A Narrative Review

Abdullah Mutlaq Farhan Almqati[(1)] , Awatef Salem Alghamdi[(2)] , Manal Jamaan Ghurmullah Mabruk[(3)] , Fahad Yahya Gassim Alfaifi[(4)] , Bander Sefar Alosaimi[(5)] , Alanood Katib Alsbity[(6)] , Amal Mohammad Aldossari[(7)] , Abeer Mohammad Shabi[(8)] , Mashael Farhan Warhan Alruwaily[(9)] , Abrar Abdulaziz Mohammad Alabdullatyf[(10)] , Mishari Fayez Ghazi Al-Mutairi[(11)] , Amira Maqbool Yehya Hakami[(12)]

(1)Al-Muzahmiyah General Hospital, Ministry Of Health, Saudi Arabia, Saudi Arabia
(2)Primary Health Care Center – Al-Baha, Ministry Of Health, Saudi Arabia, Saudi Arabia
(3)Bani Salem Primary Health Care Center, Ministry Of Health, Saudi Arabia, Saudi Arabia
(4)Eastern Health Sector – Faifa, Jazan, Ministry Of Health, Saudi Arabia, Saudi Arabia
(5)King Khalid Hospital – Al-Kharj, Ministry Of Health, Saudi Arabia, Saudi Arabia
(6)Ministry Of Health, Saudi Arabia, Saudi Arabia
(7)King Salman Hospital – Riyadh, Ministry Of Health, Saudi Arabia, Saudi Arabia
(8)Al-Badawi Health Center – Jazan, Ministry Of Health, Saudi Arabia, Saudi Arabia
(9)Al-Jouf, Ministry Of Health, Saudi Arabia, Saudi Arabia
(10)Al Iman Hospital – Riyadh, Ministry Of Health, Saudi Arabia, Saudi Arabia
(11)Artawiya General Hospital – Riyadh Region, Ministry Of Health, Saudi Arabia, Saudi Arabia
(12)King Fahad Hospital – Jazan Health Cluster, Ministry Of Health, Saudi Arabia, Saudi Arabia

Abstract

Missed nursing care, the omission or delay of required patient care tasks, is a recognized marker of workload strain and organizational weakness. Because the earliest signs of clinical deterioration are detected through routine nursing activities such as vital sign measurement, observation, documentation, and escalation, omissions in these tasks may delay recognition and rescue. This narrative review synthesizes literature from 2017 to 2025 on the antecedents of missed care, the processes through which deterioration is recognized, and the mechanisms linking the two. The evidence indicates that inadequate staffing, skill mix, unfavorable work environments, and burnout are consistent antecedents; that surveillance and monitoring tasks are vulnerable to omission; and that early-warning systems and monitoring technology depend on reliable human execution. A conceptual model, mitigation strategies, and measurement priorities are proposed, together with research gaps concerning direct evidence on causal pathways.

Keywords: missed nursing care; clinical deterioration; early warning scores; nurse staffing; patient safety.

Introduction

Hospital patients rarely deteriorate without warning. Physiological abnormalities such as rising respiratory rate, falling oxygen saturation, hypotension, tachycardia, or new confusion commonly precede cardiac arrest, unplanned intensive care admission, and death by hours, and reviews of in-hospital cardiac arrest emphasize that many events follow a period of detectable instability (Andersen et al., 2019). Early recognition and timely response are therefore central safety functions. They depend on a chain of actions: measuring and observing the patient, recording the findings, interpreting them, communicating concern, and obtaining an appropriate response. Nurses perform or coordinate most of these actions, because they are the professionals with the most continuous bedside presence.

At the same time, a substantial body of research shows that nurses often cannot complete all the care they judge necessary. This phenomenon has been described as missed care, care left undone, unfinished care, or implicit rationing, and its prevalence, causes, and consequences have been reviewed extensively (Recio-Saucedo et al., 2018; Chaboyer et al., 2021; Kalánková et al., 2020). The concept matters because the tasks most vulnerable to omission frequently include those that underpin early recognition: timely vital sign measurement, ambulation and repositioning, patient surveillance, documentation, and communication with colleagues and families. When these tasks are missed, the early signal of deterioration may never be generated, or it may be generated but not acted upon.

The broader context of patient safety makes the issue pressing. A meta-analysis estimated that about one in twenty patients experiences preventable harm in health care, with a considerable share of this harm judged to be severe (Panagioti et al., 2019), and the World Health Organization's global action plan

*Corresponding author Amalmqati@Moh.Gov.Sa (Abdullah Mutlaq Farhan Almqati).
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identifies safe staffing, workforce capability, and learning systems as strategic components of harm reduction (World Health Organization [WHO], 2021). Economic analyses suggest that avoidable harm imposes large costs on health systems, which strengthens the argument for investment in prevention (Slawomirski & Klazinga, 2022). Reviews of failure to rescue further indicate that delays in recognizing and responding to deterioration are often rooted in monitoring failures and communication breakdowns rather than in a lack of technical knowledge (Burke et al., 2022).

Despite these links, the literature on missed nursing care and the literature on deterioration recognition have developed largely in parallel. The first is concerned with workforce, work environment, and nursing outcomes; the second with early-warning scores, rapid response systems, and predictive analytics. Few syntheses examine how omissions of routine care propagate into delayed recognition of deterioration. The aim of this narrative review is therefore to integrate evidence published between 2017 and 2025 on (a) the definition, prevalence, and antecedents of missed nursing care; (b) the processes and failure modes of deterioration recognition; (c) the mechanisms through which missed care may impair early recognition; and (d) strategies that health systems and nursing leaders can use to reduce the risk.

2. Review Approach

This study follows a narrative review design, which is appropriate for conceptual integration across literatures that differ in methods and outcomes. Searches were conceptualized across biomedical and nursing databases for publications from 2017 to 2025, combining terms for missed nursing care, care left undone, unfinished care, implicit rationing, nurse staffing, work environment, clinical deterioration, early warning scores, vital signs monitoring, failure to rescue, and escalation of care. Priority was given to systematic reviews, large multi-country studies, clinical guidelines, and authoritative policy documents, supplemented by selected primary studies that illuminate mechanisms.

Evidence was appraised qualitatively for relevance, design, and applicability to adult acute care, which is the setting in which most relevant research has been conducted. Because few studies directly link specific missed care items to specific delayed recognition events, the review distinguishes between evidence for each link in the proposed chain and the inference required to connect them. As in all narrative reviews, no formal risk-of-bias scoring or quantitative synthesis was undertaken, and conclusions should be read as structured integration rather than pooled effect estimates.

3. Conceptualizing Missed Nursing Care

3.1 Definitions, terminology, and prevalence

Missed nursing care refers to any aspect of required patient care that is omitted either in part or in whole, or that is delayed. Related terms emphasize different aspects: care left undone highlights the nurse's perspective on tasks not completed, implicit rationing emphasizes decision-making under resource constraint, and unfinished care points to the interruption of tasks. An overview of reviews concluded that, despite terminological variation, these concepts overlap substantially, and that the common core is a gap between the care that is needed and the care that is delivered (Chaboyer et al., 2021). A systematic review of nursing care left undone and patient outcomes similarly treated these concepts together in order to examine consequences (Recio-Saucedo et al., 2018).

Prevalence estimates vary according to measurement approach, setting, and country, but missed care has been reported in all health systems in which it has been studied. Large cross-sectional studies in many countries show that substantial proportions of nurses report leaving at least one necessary task undone on their last shift, and that missed items often include comforting and talking with patients, patient education, documentation, mobilization, and surveillance activities (Ball et al., 2018). Most data are collected through nurse self-report using standardized surveys. This approach captures nurse perceptions of necessary care, which are valuable but may differ from objective measures, and it can be affected by recall and social desirability. Nevertheless, the consistent pattern across studies supports missed care as a valid indicator of strained care delivery (Kalánková et al., 2020).

3.2 Antecedents: staffing, skill mix, environment, and well-being

The most consistently reported antecedent is nurse staffing. A systematic review found that lower nurse staffing was associated with more omissions in nursing care, although studies varied in design and quality (Griffiths et al., 2018). A multi-country study of surgical patients reported that missed care and higher patient-to-nurse workloads were associated with higher postoperative mortality, suggesting that omissions can act as a mechanism through which staffing affects outcomes (Ball et al., 2018). Systematic evidence from acute specialist units likewise indicates that lower nurse-to-patient ratios are linked to more adverse outcomes, although effect sizes and certainty vary across outcomes (Driscoll et al., 2018).

Skill mix and nursing roles also matter. In a large European study, hospitals with a higher proportion of professional nurses in the nursing workforce had lower mortality and better patient ratings of care, whereas substitution of lower-qualified staff for professional nurses was not associated with similar benefits (Aiken et al., 2017). A longitudinal cohort study of hospital wards in England found that additional nursing assistants did not offset the effect of lower registered nurse staffing on mortality, which suggests that complementary roles cannot simply

replace the assessment and judgment functions of registered nurses (Griffiths et al., 2019). These findings are relevant to deterioration because the interpretation of observations and the decision to escalate rely on clinical judgment.

The work environment, including leadership, staffing adequacy, collegial relations, and organizational support, also shapes missed care. A study of nurse work environment, collective efficacy, and missed care found that positive environments were associated with less missed care (Smith et al., 2018), and a panel study showed that improvements in work environments and staffing were followed by reductions in missed care (Lake et al., 2020). Another study identified correlates and predictors of missed care in hospitals, including staffing, teamwork, and communication factors (Bragadóttir et al., 2017). Nurse staffing, nurse prioritization, missed care, and quality of care are interrelated, and nurses' prioritization decisions appear to mediate between resource constraints and the care that is delivered (Cho et al., 2020). Finally, burnout is both an outcome and a contributor to missed care: a theoretical review of burnout in nursing describes how excessive workload, lack of control, and insufficient reward lead to emotional exhaustion and reduced performance, which can feed back into omissions (Dall'Ora et al., 2020).

3.3 Which care is missed, and why it matters for surveillance

Care omissions are not distributed randomly. When nurses must prioritize, tasks perceived as less immediately life-critical or less visible are most likely to be deferred, such as patient education, emotional support, oral care, mobilization, and documentation. Surveillance tasks occupy an ambiguous position. Scheduled vital sign measurement is a formal requirement, but it competes with medication rounds, admissions, discharges, and unplanned demands, and frequent bedside observation between formal measurements is not scheduled at all. Patient assessment, review of trends, and communication with the team may be shortened under pressure. These are precisely the activities that allow subtle change to be noticed.

Systematic evidence links care left undone to patient harm. Reviews report associations between missed care and outcomes such as falls, pressure injuries, infections, medication errors, readmissions, and mortality, although most studies are observational and cannot establish causation (Recio-Saucedo et al., 2018; Kalánková et al., 2020). Mortality associations in particular are strongest in large cross-sectional and longitudinal designs that adjust for patient and hospital characteristics (Ball et al., 2018; Griffiths et al., 2019). The plausible mechanism, discussed in Section 5, is that missed care reduces the opportunities to detect and respond to early deterioration.

4. Early Recognition of Clinical Deterioration

4.1 The recognition-response chain

Recognition of deterioration can be described as a chain of linked steps: monitoring (measuring and observing), recording (documenting findings so that trends can be seen), interpreting (judging whether findings are abnormal and clinically significant), escalating (communicating concern to those who can act), and responding (delivering timely assessment and treatment). A failure at any link can delay rescue. Reviews of failure to rescue identify root causes at each stage, including incomplete or delayed observations, failure to recognize or interpret abnormal findings, hesitation to escalate, and delayed or inadequate response by the receiving team, with communication and organizational factors frequently contributing (Burke et al., 2022). Table 1 maps typical missed care items to each stage of the chain and to the consequences for recognition.

Table 1. Missed nursing care items mapped to stages of the recognition-response chain

Stage	Typical missed or delayed care	Consequence for recognition	Representative evidence
Monitoring	Late or incomplete vital sign sets; reduced bedside observation; missed overnight checks	Early physiological change not detected; trends interrupted	Brekke et al. (2019); Recio-Saucedo et al. (2018)
Recording	Incomplete or delayed documentation; scores not calculated	Early-warning score unavailable or inaccurate; trends hidden	Gerry et al. (2020); Williams (2022)
Interpreting	Insufficient time for assessment; reduced use of clinical judgment; lower registered nurse presence	Abnormal values not recognized as significant; context overlooked	Aiken et al. (2017); Griffiths et al. (2019)
Escalating	Hesitation to call for help; delayed communication; hierarchy and workload barriers	Delay before medical review or rapid response	Burke et al. (2022); Smith et al. (2018)
Responding	Delayed follow-up of orders; missed reassessment after intervention	Persisting instability; progression to arrest or ICU admission	Andersen et al. (2019); Ball et al. (2018)

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4.2 Early-warning scores and their dependence on human performance

Early-warning scores aggregate routine physiological measurements into a single value that triggers graded clinical responses. The National Early Warning Score 2 was introduced by the Royal College of Physicians to standardize the assessment of acute illness severity across the National Health Service, defining scoring parameters, thresholds, and recommended response levels (Williams, 2022). Comparative database studies show that the updated score has an ability to identify patients at risk of in-hospital mortality comparable to its predecessor (Pimentel et al., 2019). However, a systematic appraisal of early-warning scores for adult hospital patients found considerable variation in methodological quality, with many scores lacking rigorous validation, which underlines that choice and local verification of the tool matter (Gerry et al., 2020).

Crucially, every score depends on inputs generated by people. A score cannot be calculated if respiratory rate is not counted, and it cannot trigger a response if it is calculated late or recorded inaccurately. Respiratory rate, in particular, is a sensitive indicator that is frequently estimated or omitted in practice. Reviews of vital sign trends indicate that serial observations carry predictive information that single values lack, which means that gaps in observation sets reduce not just the value of a given measurement but the interpretability of the whole trajectory (Brekke et al., 2019). Predictive models in digital hospital environments, including those based on machine learning, similarly rely on data that are regularly, accurately, and promptly entered (Mann et al., 2021). The implication is direct: missed or delayed monitoring tasks reduce the information on which both manual and automated systems depend.

4.3 Failure to rescue and the role of escalation

Even when abnormal findings are recorded, recognition is incomplete until someone acts. Escalation requires the nurse to judge that concern is justified, to find and communicate with an appropriate colleague, and to obtain a response. Reviews of failure to rescue emphasize that organizational and communication factors, including unclear escalation criteria, hierarchical culture, high workload, and inadequate response capacity, impede this process (Burke et al., 2022). Workload is relevant at this stage because escalation takes time and cognitive capacity, which are scarce when nurses are caring for more patients than they can safely manage. Work environments that support nurses' autonomy and collegial relationships are associated with less missed care, and by extension may facilitate escalation, although direct evidence of this link is limited (Smith et al., 2018; Lake et al., 2020).

In summary, the recognition-response chain is only as strong as its weakest link, and several of its links are made of the same routine nursing tasks that are susceptible to omission when resources are constrained. The next section examines the mechanisms through which missed care can degrade early recognition and presents a conceptual model.

5. Mechanisms Linking Missed Care to Delayed Recognition

5.1 Four pathways

The literature supports a plausible, though largely indirect, set of mechanisms by which missed nursing care degrades early recognition of deterioration. Figure 1 presents a conceptual model in which organizational antecedents (staffing, skill mix, work environment, nurse well-being, and documentation burden) increase the likelihood of missed care, which in turn weakens the recognition-response chain and increases the risk of adverse outcomes. Figure 2 shows how omissions map onto the individual links of that chain. Four pathways can be distinguished.

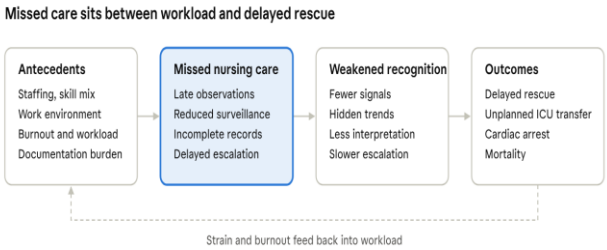


Figure 1. Conceptual model linking organizational antecedents to missed nursing care, weakened recognition of deterioration, and patient outcomes.

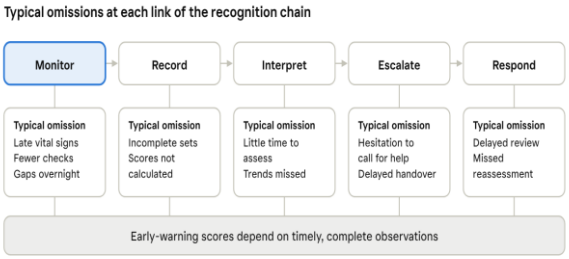


Figure 2. Typical omissions of nursing care at each link of the recognition-response chain.

The first is signal generation. Delayed or omitted vital sign measurement, reduced bedside observation, and curtailed patient contact mean that fewer data points are generated. Evidence that serial vital sign trends add predictive value beyond single readings implies that gaps in observation sets reduce the capacity to detect gradual change (Brekke et al., 2019). The second pathway is signal quality and trend visibility. Incomplete, inaccurate, or late documentation makes scores unreliable and conceals trends from colleagues who review the record. Early-warning tools are only

*Corresponding author Amalmqati@Moh.Gov.Sa (Abdullah Mutlaq Farhan Almqati).
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as sound as their inputs, and variations in validation quality already limit their reliability (Gerry et al., 2020; Williams, 2022).

The third pathway is interpretation capacity. Recognizing that a set of values signals risk requires time, knowledge, and an understanding of the patient's baseline. Workforce evidence shows that a higher proportion of professional nurses is associated with better outcomes and that nursing assistants do not offset reduced registered nurse capacity, which is consistent with a role for registered nurse assessment and judgment in recognition (Aiken et al., 2017; Griffiths et al., 2019). The ability to notice subtle changes that precede overt abnormality is also supported by studies of nurses' intuitive concern. A Dutch study of an early nurse worry indicator found that structured capture of nurses' worry contributed information about deterioration beyond routine measures, and it highlights how rushed, depersonalized care may suppress this form of recognition (Douw et al., 2017).

The fourth pathway is escalation capacity. Escalation requires time, psychological safety, and confidence that a response will follow. Studies of failure to rescue identify communication problems, hierarchy, and inadequate response systems as recurring causes (Burke et al., 2022). When nurses are overloaded, the cognitive and temporal cost of escalation competes with other urgent tasks, and when work environments are poor, hesitation may increase. A positive work environment is associated with less missed care, which suggests that the same conditions that protect basic care may also support timely escalation (Smith et al., 2018; Lake et al., 2020).

5.2 What the outcome evidence shows

Direct studies that link specific missed items to specific delayed recognition events are rare, and this is the most important gap in the field. What exists is a body of consistent but indirect evidence. Multi-country work found that missed care and unfavorable workloads were associated with higher postoperative mortality (Ball et al., 2018), and surveys of nurses and patients in hospitals continue to indicate that patient safety remains a concern in many settings (Aiken et al., 2018). Longitudinal research suggests that improvements in nursing resources are followed by improvements in patient safety and quality indicators, which supports a causal reading of the staffing-outcome association (Sloane et al., 2018). A systematic review of longitudinal studies likewise concluded that higher nurse staffing levels are associated with lower mortality and other favorable outcomes, while noting heterogeneity and the need for caution about effect size (Dall'Ora et al., 2022).

Policy evaluations are especially informative. A prospective panel study of hospitals following the introduction of nurse-to-patient ratio legislation found that mandated ratios were associated with improved staffing and with lower mortality, readmissions, and length of stay (McHugh et al., 2021). A modelling study of safe-staffing legislation estimated that such policies could be associated with fewer deaths and cost savings, although projections of this type rest on assumptions (Lasater et al., 2021). These studies do not isolate recognition of deterioration as the mediating mechanism, but they are consistent with the view that adequate staffing preserves the monitoring and surveillance activities that allow earlier rescue.

5.3 Interaction with technology

Automated and algorithmic tools are often proposed as solutions to missed monitoring, yet they interact with missed care in complex ways. A reflection on early-warning implementation illustrates the risk: in one study, deployment of an electronic early-warning score with a best-practice alert had minimal impact on patient outcomes, suggesting that alerts alone are insufficient if workflow, staffing, and response processes are not aligned (Bedoya et al., 2019). Scoping reviews of machine learning-based early-warning systems likewise highlight methodological limitations, limited external validation, and a shortage of evidence on clinical impact (Muralitharan et al., 2021). Technology thus does not remove the human dependency; it changes its nature, from measuring and calculating to responding to alerts and maintaining device and data integrity.

6. Mitigation Strategies

Strategies to reduce the effect of missed care on recognition can be organized at three levels, shown in Figure 3: the system level (staffing, policy, and learning), the unit level (work environment, workflow, and teamwork), and the bedside level (monitoring, escalation, and patient involvement). Table 2 summarizes priority actions, the links in the chain they address, and candidate indicators.

Table 2. Mitigation strategies, targeted links in the recognition-response chain, and candidate indicators

Strategy	Chain link addressed	Representative actions	Candidate indicators
Safe staffing and skill mix	Monitoring; interpreting	Evidence-informed staffing methods; protect registered nurse capacity; acuity-adjusted allocation	Hours of nursing care per patient day; proportion of shifts below target; missed-care survey scores
Healthy work environment	All links	Leadership support; collegial relations; workload and burnout monitoring	Work environment scale scores; burnout and turnover; missed-care trend

Reliable monitoring and documentation	Monitoring; recording	Scheduled observation sets; complete respiratory rate recording; reduced documentation burden	Percentage of observation sets completed on time and in full
Technology-supported surveillance	Monitoring; interpreting	Continuous or wearable monitoring in selected patients; validated scores; alert governance	Alert response time; false-alert burden; unplanned ICU transfers
Escalation and teamwork	Escalating; responding	Clear triggers; structured handover; psychological safety; response-time standards	Time from trigger to review; escalation compliance
Patient and family involvement	Interpreting; escalating	Patient-activated escalation routes; education on warning signs	Use of patient-initiated calls; related outcomes
Learning system	All links	Case review of deterioration; audit and feedback; sepsis programs	Cardiac arrests with preceding warning; review completion



Figure 3. Mitigation strategies organized at the system, unit, and bedside levels.

6.1 Staffing, skill mix, and work environment

Because staffing is the most consistent antecedent of missed care, it is the first lever. Operational research reviews describe methods for estimating nursing requirements, including acuity-based tools and simulation, and emphasize that no single method is universally optimal, so that local validation and responsiveness to changing patient acuity are important (Saville et al., 2019). Policy-based evidence supports minimum standards in some contexts (McHugh et al., 2021; Lasater et al., 2021), while research on skill mix indicates that protecting the proportion of registered nurses is important for outcome-sensitive tasks such as assessment (Aiken et al., 2017; Griffiths et al., 2019). Improvements in the work environment, including leadership, resources, and collegiality, have been associated with lower missed care and are plausible co-interventions (Lake et al., 2020; Smith et al., 2018). Attention to burnout is equally relevant, as organizational responses should address its structural determinants rather than rely on individual resilience (Dall'Ora et al., 2020).

6.2 Monitoring technology and documentation design

Continuous or wearable monitoring may reduce reliance on intermittent manual observation, particularly overnight or in units with high workloads. A systematic review and narrative synthesis of continuous versus intermittent vital signs monitoring found limited and heterogeneous evidence of clinical benefit but identified potential advantages in detection and highlighted implementation issues such as alarm burden (Downey et al., 2018). A later systematic review and meta-analysis of wearable continuous monitoring in hospitalized patients examined its effect on detection of deterioration and clinical outcomes, and it concluded that evidence of benefit remains uncertain and that study quality is a constraint (Areia et al., 2021). These findings argue for targeted deployment, careful alert governance, and evaluation rather than universal adoption.

Documentation design is another lever. Electronic health record design and use factors are associated with clinician stress and burnout (Kroth et al., 2019), and a high documentation burden competes with bedside time. Streamlined entry of observation sets, automated transfer of device data, and clear visualization of trends can reduce the effort required and improve completeness, but must be tested for unintended consequences. Predictive analytic tools should be introduced with attention to validation, calibration, and clinical workflow (Muralitharan et al., 2021; Bedoya et al., 2019).

6.3 Culture, teamwork, escalation, and patient involvement

Organizational culture influences whether nurses escalate concerns. A systematic review found that more positive organizational and workplace cultures were associated with better patient outcomes (Braithwaite et al., 2017), and meta-analytic evidence shows that teamwork is associated with performance and fewer adverse events (Schmutz et al., 2019). Structured communication tools support the transfer of critical information; a systematic review found that the SBAR tool was associated with improvements in patient safety outcomes and communication quality, although designs were heterogeneous (Müller et al., 2018). Reviews of teamwork science identify shared mental models, closed-loop communication, mutual monitoring, and leadership as core components of effective teams (Rosen et al., 2018), and a Cochrane

review supports the potential of interprofessional collaboration interventions to improve practice and outcomes when well implemented (Reeves, 2018). Structured capture of nurse concern, as in the worry indicator, can also be integrated into escalation criteria (Douw et al., 2017).

Patients and families are an additional safety resource. A systematic review of the role of patients and relatives in escalating deterioration found that they can recognize change and that formal systems for patient-activated escalation exist, although evidence on effectiveness and implementation challenges is limited (Albutt et al., 2017). Such systems require visible access routes, protection against retaliation, and responsiveness. Finally, condition-specific programs show how structured recognition can be sustained. International sepsis guidelines recommend that hospitals implement performance improvement programs for sepsis, including screening for acutely ill, high-risk patients, which relies on reliable observation and escalation processes (Evans et al., 2021).

7. Implications for Practice, Leadership, and Policy

Several implications follow. First, missed care should be treated as an early warning indicator for the organization, comparable to a rising infection rate. Routine measurement of missed care, through validated surveys or electronic proxies such as observation timeliness, can show where recognition is at risk before harm occurs. Second, nursing leaders should monitor not only staffing numbers but the match between staffing and acuity, and should escalate when safe care cannot be provided. Third, early-warning systems should be implemented as complete socio-technical systems that include staffing, training, escalation pathways, and response capacity, not simply as scores or alerts.

Fourth, learning systems should examine deterioration events for the presence of missed monitoring, delayed documentation, and escalation barriers, using findings to guide improvement. The progress of patient safety reform over two decades suggests that sustainable improvement requires measurement, leadership, and the integration of safety into everyday work (Bates & Singh, 2018). Finally, policy-makers should consider minimum staffing requirements and workforce planning alongside investment in technology, given the evidence on staffing and outcomes (McHugh et al., 2021; Dall'Ora et al., 2022).

8. Research Gaps and Future Directions

Several gaps limit confident conclusions. First, there are few studies directly linking specific missed care items, such as late observation sets, to specific delayed recognition or rescue events, and most evidence is observational and cross-sectional (Recio-Saucedo et al., 2018; Kalánková et al., 2020). Second, measurement of missed care depends heavily on self-report; objective measures derived from electronic records, such as timeliness and completeness of observations, should be developed and validated alongside survey instruments. Third, trials and quasi-experimental evaluations are needed on the effect of staffing and work environment interventions on deterioration-specific outcomes. Fourth, evidence on continuous monitoring and machine learning tools requires prospective evaluation with attention to workload, alert burden, equity, and clinical effectiveness (Areia et al., 2021; Muralitharan et al., 2021). Fifth, most research originates from high-income hospital settings, and the applicability to community, long-term care, and low-resource contexts is uncertain. Sixth, qualitative and mixed-methods studies of nurses' decision-making about prioritization and escalation under pressure would illuminate mechanisms that quantitative studies cannot.

9. Limitations

This review has limitations inherent in the narrative design. The search was not systematic, no formal risk-of-bias assessment or quantitative synthesis was conducted, and selection of sources may reflect reviewer judgment. The conceptual model links two literatures through inference, and direct evidence for several pathways is limited. The restriction to 2017–2025 may have omitted earlier foundational studies, and findings from adult acute care may not generalize to pediatric, maternity, or community settings.

10. Conclusion

Missed nursing care and delayed recognition of clinical deterioration are connected through the routine tasks of monitoring, recording, interpreting, escalating, and responding. When staffing, skill mix, and work environments cannot support these tasks, the signals that allow early rescue may not be generated, may not be visible, or may not be acted upon. The evidence reviewed is consistent in showing that nurse staffing and work environment influence missed care and outcomes, that early-warning tools depend on reliable human execution, and that technology and algorithmic aids do not remove this dependency. Health systems should therefore treat missed care as a safety signal, invest in safe staffing and healthy work environments, design monitoring and documentation to reduce burden, strengthen escalation and teamwork, involve patients and families, and evaluate improvements using both process and outcome indicators. Closing the evidence gap on the direct pathways from omission to delayed recognition is the priority for future research.

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