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EDITORIAL

Missed nursing care and related concepts: two decades of research and the road ahead

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Research in the field of missed nursing care (MNC) and related concepts, such as unfinished nursing care or rationed care, which refer to nursing activities that are omitted or delayed despite being expected by patients (Bassi et al., 2018), is approaching its 20th anniversary. Attempting to measure what has not been provided to patients – something inherently invisible yet crucially related to the quality of care – has attracted considerable international interest (Jones et al., 2021). Over the years, researchers from around the world (Sarpong et al., 2023) have developed a variety of measurement instruments, validated their psychometric properties, and mainly measured the occurrence of MNC. Overall, the results have documented consistency in the incidence and patterns of omitted care across different cultures, healthcare systems, and organizational conditions (e.g., Zeleníková et al., 2023) – even despite significant differences in staffing, resources and infrastructure.

During the COVID-19 pandemic, renewed debate on this line of research emerged. Several studies have sought to understand whether the occurrence or nature of MNC changes under extreme systemic stress. Surprisingly, many of these studies showed results consistent with pre-pandemic patterns. These results are all the more remarkable considering they were based on self-reporting during one of the most disrupted periods in healthcare history worldwide (Sist et al., 2024). Prior to the pandemic, MNC research was primarily conducted in hospitals, with data collected through self-report using validated instruments, and the studies were mainly cross-sectional. During the pandemic, two lines of research were developed: (a) comparative studies investigating differences in the care of COVID-19 and non-COVID-19 patients and (b) studies tracking the prevalence of MNC independent of the pandemic context. The former represented an innovation, as comparative studies on MNC previously were rare and largely limited to unit- or country-level comparisons under stable conditions. The latter helped document the persistence of the phenomenon and further validate existing instruments (Bayram et al., 2024). Methodologically, however, these studies continued to rely on traditional instruments and self-reporting. When pre-pandemic data was available, researchers were able to compare results within the same hospital departments and sometimes with the same nursing staff, minimizing potential confounding variables. Nevertheless, the striking stability of MNC patterns – despite the extraordinary stresses of the pandemic – calls for methodological innovation and deeper conceptual thinking about the phenomenon (Chiappinotto et al., 2023).

As MNC research has reached a certain level of maturity, a new course should be taken in this area. Here are some non-exhaustive considerations based mainly on our research experience in the field (Sarpong et al., 2023):

The variety of instruments and their comparability. There are now multiple instruments for assessing MNC, including context- and patient-specific ones. We are arguably entering the third generation of measurement instruments in this area. The first generation was represented by the MISSCARE Survey guided by the original conceptualization of MNC. The second generation was represented by instruments developed within the unfinished nursing care concept, which introduced updated conceptual frameworks and structures (Palese et al., 2021). The development of these tools is an incredible process that fosters connections around the world and increases precision. However, it has made comparability between different studies, settings, and countries difficult. Though they all aim to measure the prevalence of MNC, particularly in hospitals, they differ considerably in terms of time frame, response scales, and inventory of care activities. In addition, they are all based on self-report and therefore reflect subjective perceptions of care influenced by various factors, including nurses' attitudes, accountability, and moral competence, as well as contextual and organizational factors.

The conceptual gaps in measurement. Fundamental questions remain about what is being measured. Most instruments do not consider care at the individual patient level, so they do not reflect the principles of person-centered care. In addition, MNC instruments generally measure tasks rather than processes. However, modern definitions of nursing care – such as the recent one by the International Council of Nurses (White et al., 2025) – emphasize nursing care as a process that includes both visible actions and invisible cognitive processes. Many instruments also incorporate contributions or measurements from nursing assistants, which further complicates the conceptual clarity of what is being assessed. Another limitation is the lack of distinction between episodic and systemic MNC (Saiani & Di Giulio, 2018). The former can be troublesome and infrequent, while the latter indicates persistent failures with potentially irreparable consequences for patients, nurses and healthcare systems (Palese et al., 2023).

Deepening decision-making processes. One of the most interesting areas for future study is why nurses prioritize – or do not prioritize – certain activities over others. In other words, why do nurses defer or skip some activities but not others? Research has shown that these decisions depend on several factors, such as how nurses conceptualize care, organizational models of care, and the value they (and the system) place on different care interventions (Sist & Palese, 2020). For example, Jones et al. (2021) found that nurses tend to prioritize activities that (a) have an immediate, visible impact on patients, (b) require a controlled amount of time, (c) are predictable in duration, and (d) are subject to external or internal control (e.g., medication schedules or family expectations). The fact that these prioritization patterns were maintained despite radically changed working conditions during the pandemic – as evidenced by the same activities being missed according to available studies – may indicate that nurses are constantly forced to make decisions under conditions of scarcity. They likely relied on familiar decision-making strategies as coping mechanisms in the face of stress and uncertainty. However, it is also possible that nurses relied on deeply held ethical beliefs to maintain a minimum standard of care and encountered exceptional constraints in doing so. This may help explain the widespread moral despair and emotional exhaustion (Lake et al., 2022) that contributed to the post-pandemic phenomenon known as the Great Resignation in nursing and other healthcare professions.

Analyzing declines in participation rates. Response rates in MNC research have declined over time. During the pandemic, participation dropped to as low as 17.9%, compared to around 50% before the pandemic (Chiappinotto et al., 2023). Contributing factors included deprioritization of data collection, fear of infection from paper questionnaires, survey fatigue, and frustration with studies that provided little benefit. Many nurses were asked to complete anonymous surveys reporting missed care while being excluded from decision-making processes, which undermined their motivation to participate.

Delayed or non-existent feedback loops. Another major problem that can also (and not only) impact participation rates is the lack of real-time feedback for nurses and managers. Current evaluation systems often only provide data once a study has been completed, if at all. This delay prevents real-time benchmarking and organizational learning. To truly address MNC, systems need objective, timely, and digital tools that can identify care failures, especially preventable ones, at the patient level for immediate action.

Moving from diagnosis to action. While measurement remains critical, the field must now decisively transition from diagnosis to intervention. Important studies have already begun exploring the causes of MNC and evaluating the effectiveness of strategies to mitigate or prevent it. If we continue to monitor the problem without taking action, research may become ethically questionable. Nurses, managers, and systems must be empowered to not only recognize and prevent MNC through better organizational design, educational strategies, staffing, and support (Chiappinotto et al., 2022).

All these considerations are not conclusive; rather, they are a call to revitalize the conceptual and practical significance of MNC research. This requires a renewed focus on the importance and impact of missed care and its measurement using less complex, practice-oriented (rather than just research-orientated) tools that can capture neglect in real time and inform action. In addition, innovative approaches must be developed to better address the underlying complexity of care work and decision-making. Future research should focus on developing instruments that differentiate between episodic and systemic care failures, consider context at the patient and organizational levels, and provide actionable insights to improve care in real time. In this context, digitalization can tremendously help refine instruments. Furthermore, the MNC research

phase must ask not only what is missing, but also *why*, for *whom*, and — most importantly – *how* this can be prevented.

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