

Nursing: Ethical Dimensions and Patient Safety Impacts of Artificial Intelligence-Assisted Clinical Decision-Making in Critical Care Nursing: A Qualitative Systematic Review

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Index Terms:

Artificial intelligence, Bioethics, Clinical decision support systems, Critical care nursing, Digital workflow friction, Patient safety, Qualitative systematic review

Abstract. Artificial intelligence (AI) and machine learning clinical decision-support systems (CDSS) are changing the workflow of critical care nurses, delivering automated physiological monitoring, predictive deterioration signals and track-and-trigger warnings. By providing real-time predictive insights, these computational tools improve patient outcomes. However, it raises bioethical issues and transforms bedside clinical assessments. While a thorough quantitative assessment has been conducted on the accuracy of artificial intelligence, the qualitative navigation of care nurses is essential to address issues of ethics, professional autonomy, and patient safety risks. Critical care nurses' experiences with artificial intelligence-based clinical decision-making are studied in this empirical qualitative study. From inception until 2026, researchers used PubMed, CINAHL, Scopus, and ScienceDirect as reference sources. Included in the following criteria: peer-reviewed empirical qualitative studies; registered nurse research in critical care, ICUs, and NICUs using artificial intelligence/CDSS technology; emphasis on patient ethics and safety; and access to complete English texts. The CASP Qualitative Checklist evaluates ten research that meet all inclusion criteria. The synthesis yields three key concepts: automation has a bias over clinical intuition; accountability for AI-driven clinical errors; and digital workflow friction that affects timely patient interventions. Uncalibrated alerts, non-transparent assessment models, and ambiguity of responsibility lead to cognitive burden, desensitization of warnings, and escalation delays. The safety of sociotechnical integration includes institutional nursing discretion, calibrated alert thresholds, and transparent override processes.

Introduction

This computational tool improves patient outcomes by providing predictions in real-time. However, it leads to bioethical issues and transforms clinical assessment. The qualitative navigation of care nurses is essential to address issues of ethics, professional autonomy, and patient safety risks. This is despite the fact that a thorough quantitative evaluation has been conducted of the accuracy of artificial intelligence. This empirical qualitative study examines the experiences of critical care nurses using artificial intelligence to make clinical decisions. Researchers will use PubMed, CINAHL, Scopus, and ScienceDirect as reference sources from inception to 2026. Included in the following criteria are: peer-reviewed, empirical qualitative studies; registered nurse studies using artificial intelligence/CDSS technology in critical care, ICUs, and NICUs; emphasis on patient ethics and safety; and access to complete English texts. The CASP Qualitative Checklist evaluated ten studies that met all inclusion criteria. Three key concepts emerged from the synthesis: automation has a bias against clinical intuition; accountability for AI-driven clinical errors; and digital workflow friction that affects timely patient interventions. Cognitive burden, warning desensitization, and escalation delays are caused by

unclear assessment models, uncalibrated warnings, and ambiguity of responsibility. Institutional nursing discretion, calibrated warning thresholds, and transparent override processes are security features of sociotechnical integration.

Research Problem

As nurses face qualitative and human-centered problems when they use bedside algorithmic results, quantitative testing evaluates predictive indicators. Bedside algorithm recommendations that lack clinical evidence harm patient safety and ethics. Critical care nurses are faced with the burden of invasive digital alarms that interfere with patient care, unclear risk assessments, and legal accountability for adverse events caused by machines (Alhmoud et al., 2022; Assab, 2026; Rayan, 2024). There is not much systematic qualitative research that takes into account the effects of ethical friction on clinical judgment, precise escalation times, and patient safety outcomes, although there is individual qualitative research across acute settings.

Objectives of the Study

The purpose of this systematic qualitative analysis is to address the following shortcomings:

1. To determine and incorporate important ethical aspects that critical care nurses need to consider when using AI-based clinical decision-making tools.
2. To examine clinical assessments, professional intuition, and automation biases influenced by digital workflows and algorithm design constraints.
3. To find out how AI decision support influences patient safety decisions at the patient's bedside, such as deterioration identification, alarm handling hazards, and escalation speed.

Assumptions of the Study

This systematic review considers that the main qualitative narrative accurately shows professional ethics and the actual conditions at the nurse's bedside. Primary investigators followed strict qualitative data collection, participant protection, and reflective analytic procedures. Common clinical urgency and critical care routines justify cross-contextual synthesis across varied intensive care settings. Additionally, the Critical Appraisal Skills Program (CASP) Qualitative Checklist is expected to assess primary qualitative methodological quality accurately.

Methodology

Research Design

Using qualitative thematic synthesis, this systematic evaluation of qualitative research combined primary data from a variety of high-acuity and critical care clinical settings. This method uses primary qualitative research to develop a high-order conceptual model of critical care nurses' AI and clinical decision-support system experiences. The entire review methodology was designed and applied according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement to ensure methodological rigor, replicability and procedural transparency. Researchers conducted searches through the online databases PubMed, CINAHL, Scopus, and ScienceDirect from the time they were initially established until 2026.

After eligibility evaluation, 184 papers were excluded because they were not primary qualitative research, technical benchmarking models, or software optimisation techniques performed by human nurses. The eligibility of 68 full-text reports was verified. Further assessment excluded 55 quantitative clinical trials without qualitative narrative depth, ethical or patient safety focus, or bedside escalation and decision-making workflow evaluation. Finally, 13 primary empirical qualitative studies met all requirements and were synthesised. Table 1 presents the inclusion and exclusion criteria. Table 1 presents the inclusion and exclusion criteria. Schematics of the study process using the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flowchart can be seen in Figure 1.

Inclusion Criteria (Eligible)		Exclusion Criteria (Ineligible)	
1.	Qualitative research requires the collection and analysis of empirical, qualitative, and mixed data.	2.	Review papers, conceptual frameworks, and essays from quantitative studies without qualitative narratives.
3.	Studies of critical care, ICU, and NICU registered nurses and clinical personnel who have used AI-assisted decision-making or CDSS systems.	4.	Purely computational algorithmic benchmarks, machine learning model evaluations, or software architectures without bedside nurse input.
5.	In-depth analysis of ethics (autonomy, responsibility, transparency) and patient safety	6.	Studies that ignore human bedside experiences, ethics, or nursing patient safety.

- (deterioration identification, alarm handling, escalation timeliness).
- | | |
|--|---|
| 7. Peer-reviewed academic journal articles. | 8. Non-peer-reviewed presentations, commentary, editorials, blogs, trade reports, and articles. |
| 9. Published in English since the database's establishment until 2026. | 10. Studies published in languages other than English. |
| 11. Accessible full-text articles for methodological and qualitative data synthesis. | 12. Reports, book chapters, or publications without accessible full text (e.g., abstract-only, paywalled without access). |

Table 1. Inclusion and exclusion criteria of the study

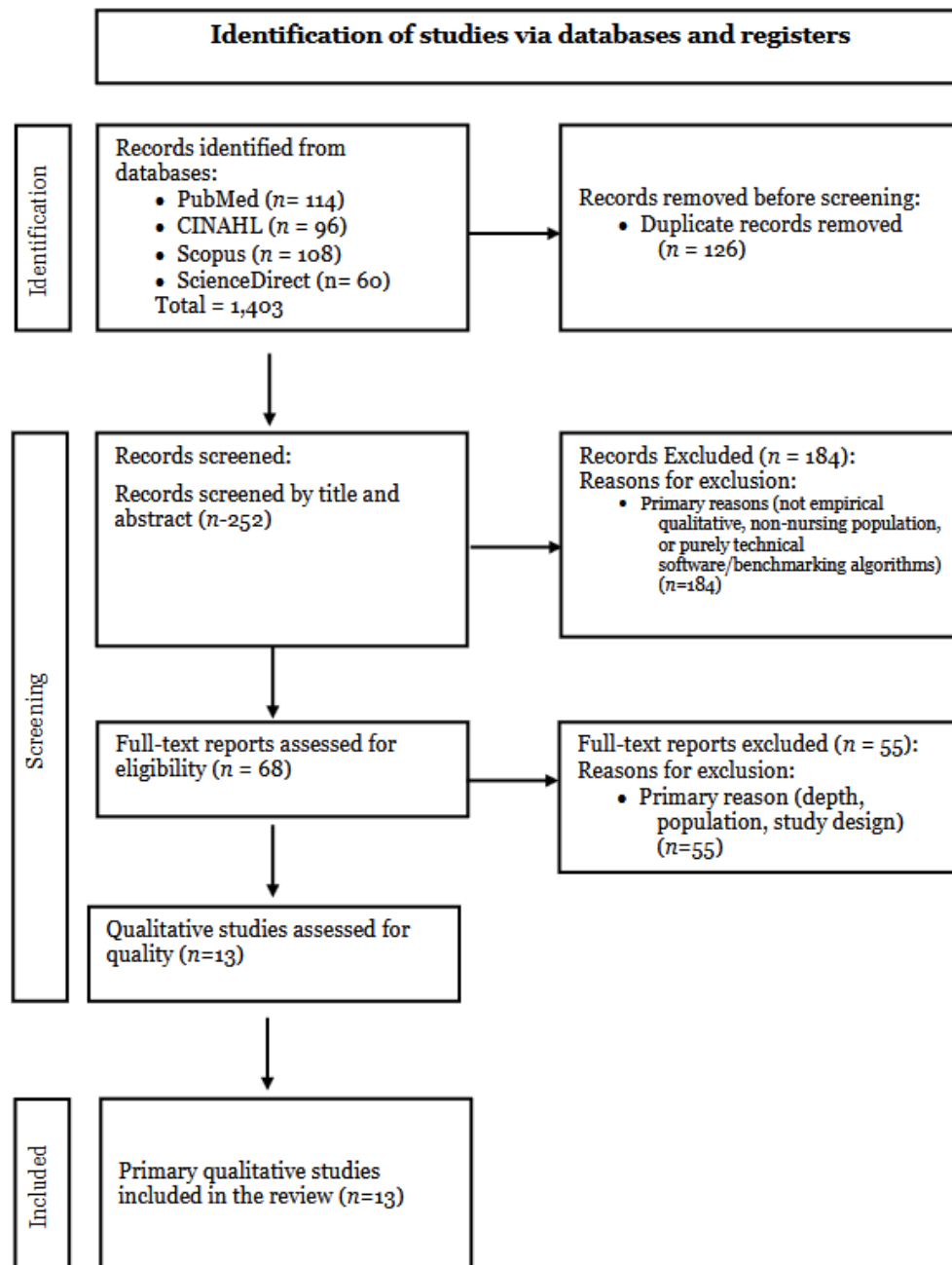


Figure 1. PRISMA flowchart Qualitative Appraisal

The 13 primary qualitative studies were evaluated using the 10-item Critical Appraisal Skills Program (CASP) Qualitative Checklist. Each study was assessed for clarity of research goals, qualitative technique, research design, recruitment strategy, data collection, and researcher reflexivity. Moreover, participant relationships, ethical rigor, robustness of analysis, clarity of findings and clinical value. The thirteen empirical investigations passed the main CASP quality standards for reporting, method clarity, and idea credibility. Table 2 shows the item-by-item CASP quality assessment results.

Author	Clear aim	Qualitative method	Design	Recruitment	Data collection	Reflexivity	Ethics	Analysis	Clear findings	Value
Alhmoud et al. (2022)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Alruwaili et al. (2025)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Assab et al. (2026)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bodur et al. (2025)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Burke & Conway (2022)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Davidson et al. (2025)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Funer et al. (2023)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mølgaard et al. (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nadaf et al. (2024)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rayan et al. (2024)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rony et al. (2024)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Wieben et al. (2024)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yildirim et al. (2026)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Table 2. Quality appraisal outcome using CASP

Data Analysis

To find, translate, and integrate patterns in qualitative research, thematic synthesis—a qualitative review method—is used to evaluate empirical findings. Synthesis consists of three stages:

1. **Line-by-Line Coding**
Thematic analysis includes line-by-line discussion, reading and coding of the results of specific publications. Initial codes, AI-based clinical decision support tools, algorithmic trial triggers and alerts, and predicted deterioration scores are all components in this step to record a hands-on nursing experience.
2. **Descriptive Theme Development**
Then, a "descriptive theme" is used to compare the selected articles. Ethical constraints in high-level and neonatal critical care include automation bias, accountability issues, and digital workflow friction.
3. **Abstraction and Conceptual Integration**
The "descriptive theme" has been improved to improve abstraction. This research incorporates theme categories and describes how algorithmic tools interact with patient safety outcomes and patient clinical intuition. These theme categories retain basic principles and incorporate additional principles.

Results and Discussion

Results

The qualitative synthesis includes 13 studies. These investigations were carried out in the UK, US, Germany, Denmark, Turkey, Saudi Arabia, Jordan, Lebanon, Ireland and Bangladesh. Eight of the thirteen studies used individual in-depth interviews (IDI); two used focus group discussions (FGD); two used iterative user-centered co-design sessions alongside clinical interviews; and one used focused ethnography. Along with other healthcare professionals who use algorithmic decision-support systems, the study participants were registered critical care nurses who work in adult intensive care units (ICU), neonatal intensive care units (NICU), and acute high-dependency wards. We evaluated attending intensivists, prospective doctors, and acute care professionals responsible for escalating patient deterioration alongside bedside clinical nurses. Table 3 summarises the included studies.

Table 3. Summary of the included studies

No.	Country	Author	Aims	Research Design	Data Collection	Qualitative Analysis
1	United Kingdom	Alhmoud et al. (2022)	To evaluate the implementation barriers, EHR integration friction, and workflow disruption of digital early warning scores (NEWS2)	Qualitative case study	Semi-structured IDI and observations with 26 clinical staff and nurses	Framework thematic analysis
2	Saudi Arabia	Alruwaili et al. (2025)	To investigate neonatal nurses' experiences and clinical decision-making with generative AI and algorithmic support in high-risk NICUs	Qualitative exploratory study	Semi-structured IDI with 16 NICU nurses	Thematic analysis

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Table 3. (Continued)

No.	Country	Author	Aims	Research Design	Data Collection	Qualitative Analysis
3	Jordan	Assab et al. (2026)	To assess healthcare professionals' trust, accountability perceptions, system readiness, and clinical judgment in AI-assisted decision-making	Qualitative exploratory design	Semi-structured IDI with 24 healthcare professionals and critical care nurses	Thematic framework analysis
4	Turkey	Bodur et al. (2025)	To examine nurses' perspectives on opportunities, ethical challenges, and accountability ambiguities of AI integration	Qualitative descriptive design	Semi-structured IDI with 22 clinical nurses	Content analysis
5	Ireland / UK	Burke & Conway (2022)	To identify factors influencing hospital nurses' clinical escalation decisions in response to track-and-trigger early warning scores	Qualitative evidence synthesis	Synthesized qualitative findings from 17 primary acute care studies	Thematic synthesis
6	United States of America	Davidson et al. (2025)	To evaluate provider workflow fit, visualization needs, and alert prioritization through user-centered CDSS co-design in the ICU	Qualitative co-design study	Multi-session co-design and IDI with 20 critical care clinicians and nurses	Inductive thematic analysis
7	Germany	Funer et al. (2023)	To explore clinicians' responsibility attributions and decision-making authority when using ML-driven clinical decision support systems	Empirical-ethical qualitative study	FGD with 32 prospective clinical professionals and nurses	Inductive content analysis
8	Denmark	Mølgaard et al. (2021)	To investigate nurses' ambivalence and the tension between clinical intuition and algorithmic early warning scores	Focused ethnography	Participant observation and informal bedside IDI with 19 nurses	Interpretive thematic analysis
9	United Kingdom	Nadaf et al. (2024)	To identify critical risk points, automation deference, and escalation challenges in registered nurses' use of national early warning scores	Qualitative descriptive design	Semi-structured IDI with 21 acute care registered nurses	Thematic analysis

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Table 3. (Continued)

No.	Country	Author	Aims	Research Design	Data Collection	Qualitative Analysis
10	Lebanon	Rayan et al. (2024)	To explore ICU nurses' lived experiences, barriers, and alarm-handling hazards regarding intelligent patient monitoring systems	Qualitative phenomenological study	In-depth semi-structured IDI with 15 critical care nurses	Phenomenological thematic analysis
11	Bangladesh	Rony et al. (2024)	To investigate nurses' perspectives on privacy boundaries, ethical	Qualitative descriptive design	Semi-structured IDI with 28 registered nurses	Thematic analysis

12	United States of America	Wieben et al.	concerns, and data governance regarding AI adoption To evaluate nurses' perceptions of the design, workflow implementation, and adoption of machine learning clinical decision support PDF	Qualitative descriptive study	Semi-structured with 25 acute and critical care nurses	IDI	Conventional content analysis
13	Turkey	Yildirim et al. (2026)	to examine the perspectives of intensive care nurses, autonomy concerns, and governance expectations regarding AI	Qualitative descriptive study	Semi-structured with 18 ICU registered nurses	IDI	Thematic analysis

Using thematic analysis, the findings of this review are divided into three topics: first, the bias of automation versus clinical intuition; second, accountability for clinical errors caused by artificial intelligence; and third, the friction of digital workflows that affect timely patient interventions.

Theme 1: Automation Bias Versus Clinical Intuition

Between the implicit experience assessment of critical care nurses and the output of algorithmic traces and triggers, there are consistent epistemic and cognitive differences. Machine learning risk predictors and automated decision support systems are recognized as additional "safety nets". According to Alruwaili and colleagues, Nurses argue that algorithm outputs, according to Wieben et al. (2025) and Yıldırım et al. (2026), should be validated based on a thorough bedside assessment to determine subtle physiological deterioration. Automation bias can occur as a result of high clinical acuity, cognitive fatigue, and rapid decision latency. In this case, nurses prioritize algorithmic risk scores over physical findings (Burke & Conway, 2022; Mølgaard et al., 2021). Additionally, in studies by Burke & Conway (2022), Mølgaard et al. (2021), and Nadaf et al. (2024), nurses experienced cognitive impairment when the predictive score did not exceed the threshold of escalation, even if the patient showed signs of physical decline, such as changes in respiratory work, spots on the body, or minor changes in neonatal behavior. This tension is especially prevalent among junior nurses and new nurses, who are more likely to experience the effects of algorithmic respect. Loss of skills, delayed care, and reduced awareness of bedside situations can be caused by hierarchical ward dynamics and low confidence (Nadaf et al., 2024).

Theme 2: Accountability for AI-Driven Clinical Errors

Institutional and bioethical fault lines in critical care settings include taking moral, legal, and professional responsibility for clinical errors or near-fatalities in AI-assisted workflows. When institutional regulations force staff to follow an automated escalation process, bedside nurses report severe psychological pain and vulnerability due to accountability gaps. Human clinicians will be solely responsible for unfavourable patient outcomes, according to Bodur et al. (2025) and Yıldırım et al. (2026). Therefore, healthcare providers can only trust algorithmic tools if they have epistemic transparency, local clinical validation measures, and clear documentation channels to support their decisions. Defensive nursing behaviors have emerged due to the absence of a formalised governance framework defining where ultimate decision-making authority resides: bedside nurses, attending intensivists, hospital risk-management groups, or software designers. For example, utilising an excessive number of confirmatory charts and being hesitant to initiate urgent treatments without getting approval from multiple healthcare professionals (Bodur et al., 2025; Funer et al., 2023; Yıldırım et al., 2026).

Theme 3: Digital Workflow Friction Compromising Timely Bedside Interventions

Instead of enhancing bedside vigilance, poorly integrated clinical decision-support frameworks caused sociotechnical and operational friction that endangered patient safety (Alhmoud et al., 2022; Rayan, 2024). Due to insufficient alert specificity, non-actionable predictive warnings, and uncalibrated threshold bounds, critical care nurses experienced alert and alarm fatigue (Davidson et al., 2025; Rayan, 2024). Alert desensitization is caused by persistent sensory attacks. This increases the likelihood that physiological collapse signals are muted, reduced in priority, or ignored during high-severity changes (Davidson et al., 2025; Rayan, 2024). Hospital electronic health records and stand-alone AI technology have poor interfaces and interoperability, which makes this problem worse. Duplication of manual data entry through non-communicative screens reduces time for tactile nursing interventions and direct physical monitoring (Alhmoud et al., 2022; Rayan et al., 2024). To reduce this operational stress, bedside workers often resort to informal solutions, such as turning off alert modules, delaying system data verification, or taking ad-hoc notes. This causes acute latent security threats to intensive care units, hinders the audit trail between professionals, and slows down the mobility of rapid response teams (Alhmoud et al., 2022; Nadaf, 2024).

Discussion

There are ethical and operational tensions in artificial intelligence-based clinical decision-making systems and digital early warning in Turkey, Saudi Arabia, Jordan, Germany, Denmark, the UK, Ireland, Lebanon, Bangladesh, and the United States, according to the study. Digital workflow disruption and alert fatigue are the most common patient barriers. However, clinical rejection of predictive technologies is the rarest. Clinical vulnerability and provider negative reactions are caused by uncalibrated alert thresholds, gaps in EHR interoperability, institutional liability protections, and vague escalation hierarchies (Alhmoud et al., 2022; Bodur et al., 2025; Rayan et al., 2024). The behavior of technology systems without interpretive transparency, workflow coordination, and clinical adaptability is hampered by moral distress and cognitive fatigue. In addition to causing a constant sensory overload, non-integrated monitoring tools quickly damage clinical trust and professional trust. Informal solutions, respect for unquestionable automation, and tolerance for warnings are the result of feelings of helplessness and abrupt delays in decisions in the context of high acuity.

Conclusion and Recommendations

Conclusion

Through 13 qualitative investigations, this systematic review shows how AI-based clinical decision support is changing the way critical care nursing is performed. Data show loss of clinical discretion at bedside, uncalibrated predictive alerts, metric opacity, and acute alert fatigue. To compensate for implicit clinical intuition and misaligned machine scores in high-severity conditions, nurses under time pressure may resort to informal interface solutions or doubt signals of physical deterioration. Automated systems must prioritize professional nursing discretion, transparent algorithmic reasoning, and strong human oversight in a loop over computational optimization to achieve sustainable sociotechnical integration in intensive care.

Implications

These decisions have a significant impact on hospital leaders, nursing management, and medical software developers who use clinical artificial intelligence. Healthcare organizations should not use technology unilaterally. They also need clear institutional override procedures, clear risk assessment rubrics, and a formal, no-penalty framework to protect nurses when machine advice overrides clinical intuition. To protect patient safety, reduce cognitive burden, and prevent warning tolerance that delays resuscitation, regulatory bodies and health informatics teams must mandate algorithmic alert threshold audits and seamless integration of electronic health records. Finally, critical care nursing education must include comprehensive digital health and bioethics training to improve bedside situational awareness and algorithm literacy.

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Competing Interests Statement

The authors declare no financial, personal, or professional interests that could have influenced this paper's findings.

Data Availability Statement

All data used in this systematic review are derived from widely available primary qualitative research, which is mentioned in the papers and tables. The authors provide a synthesis data matrix, search strings, and complete assessment logs for reasonable academic queries.

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Appendices

No appendices are attached to this study.