Original Article

Investigating the relationship between moral sensitivity and missed nursing care among nurses: a cross-sectional study

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Abstract

Missed nursing care is a significant issue in healthcare systems that can compromise patient safety. The present study aimed to investigate the relationship between moral sensitivity and missed nursing care among nurses. This descriptive-correlational study was conducted in 2024. A sample of 120 nurses from the internal and surgical wards of educational hospitals in Urmia was selected using quota sampling. Data collection tools included a demographic information form, Lutzen's Moral Sensitivity Questionnaire, and Kalisch's Missed Nursing Care Questionnaire. Statistical analysis was performed using Pearson's correlation coefficient, multiple regression, independent t-test, and one-way ANOVA in SPSS version 26. The mean score for moral sensitivity was 76.45 ± 4.7, and for missed nursing care, it was 46.45 ± 5.5. A significant inverse correlation was observed between moral sensitivity and missed nursing care ($r = -0.25$, $P < 0.05$). Additionally, education level and work shift were significantly associated with missed nursing care ($P < 0.05$). The findings indicate that higher moral sensitivity among nurses is associated with a lower incidence of missed nursing care. Therefore, it is recommended that managers develop programs to enhance nurses' moral sensitivity to reduce missed nursing care and improve the quality of nursing care.

Keywords: *Moral sensitivity; Missed nursing care; Nurse.*

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Introduction

As the most numerous healthcare professionals, nurses hold the main responsibility for patient care and are vital in fostering and sustaining health across different healthcare system levels (1, 2). Their core role involves tackling the actual and potential issues of patients, families, and communities, with effective frontline care leading to improved patient satisfaction and health results (3). Access to safe and thorough care is a key patient's right, but staffing shortages often result in some nursing tasks being neglected (4).

Missed nursing care is a newly defined concept referring to any aspect of required patient care that is omitted or delayed due to negligence (5). This phenomenon is not only a type of nursing error that impacts patient safety but also violates patients' rights, hindering their recovery and rehabilitation (4). The concept of missed nursing care was first described by Kalisch in 2006, who identified nine types of missed care (6). This framework incorporates structural factors like hospital attributes, unit-specific features, staff outcomes, and patient outcomes. The science of missed nursing care is still in its early stages, requiring further studies to increase awareness (7). Factors related to human resources, financial resources, and communication can lead to care deficiencies (8). Missed nursing care consistently results in consequences such as prolonged hospital stays, reduced patient satisfaction and safety, decreased hospital credibility, and medication errors (9).

Although missed nursing care is a significant concern in acute care settings worldwide, it has become an undiscussed topic in care units due to nurses' feelings of guilt, inability to address the issues, and fear (10). Hessels et al. reported missed nursing care rates of 10–27%, while Blackman et al. reported a rate of 34% (3, 11). Studies in Iran indicate that missed nursing care is a common problem in hospitals, highlighting the need for further research, particularly to identify factors contributing to this issue (12). Dehghan-Nayeri et al. identified structural factors, infrastructural barriers, and challenges in reporting missed care as related factors (13).

One factor that may influence the quality of nursing care and, consequently, missed nursing care is moral sensitivity. Moral sensitivity is a

characteristic that enables individuals to recognize ethical issues and view them from an ethical perspective (14). It sensitizes nurses to ethical dilemmas in hospital settings, enabling them to make ethical decisions that build trust and confidence in patients receiving care (15). Studies in Iran suggest that nurses often fail to apply ethical principles effectively in decision-making due to the lack of formalized ethical guidelines (16).

Nurses are morally accountable and must be responsible for their actions. Patient care is a central concept and the essence of the nursing profession, and nurses require personal, social, ethical, and spiritual competencies to provide optimal and ethical care (17). As healthcare professionals, nurses must understand ethical decision-making frameworks and uphold patients' ethical rights while preserving their own moral integrity (18). According to Goethals et al., the inability to address ethical challenges may lead some nurses to leave the profession or seek a change in their work position. Developing moral sensitivity fosters a foundational attitude and response in nurses, enabling them to provide effective and ethical patient care. It also requires nurses to be aware of and interpret patients' verbal and non-verbal cues to identify their needs (19). Ethical decision-making and understanding the rationale behind decisions are integral to nurses' daily work, as the nursing care domain is fraught with dilemmas requiring ethical resolutions (20).

Existing research has identified structural factors, staffing shortages, and communication barriers as key contributors to missed nursing care, but the role of individual nurse attributes such as moral sensitivity remains underexplored. Moral sensitivity enables nurses to make ethical decisions amid dilemmas and must not be overlooked as a modifiable factor that could potentially enhance care quality through targeted training programs. In Iran, where nurses often face ethical challenges in the absence of formalized guidelines, investigating this link could inform policy interventions to bolster moral competencies, reduce care omissions, and foster a more resilient nursing workforce, ultimately improving patient outcomes and healthcare equity in acute settings. Thus, this research was carried out to explore the connection between moral sensitivity and instances of missed nursing care among nurses employed in the internal and surgical wards of teaching hospitals associated with Urmia University of Medical Sciences.

Methods

This descriptive-correlational study was conducted in 2024 on nurses working in internal and surgical wards of four educational hospitals affiliated with Urmia University of Medical Sciences in Urmia, Iran (Imam Khomeini Hospital, Taleghani Hospital, Motahari Hospital, and Kosar Hospital). The study population consisted of approximately 480 nurses who met the inclusion criteria. Sampling was conducted from April 9, 2024, to June 9, 2024, using quota sampling with proportional allocation based on the number of nurses in each hospital.

Inclusion Criteria:

- Having at least 6 months of continuous work experience in internal or surgical wards (a minimum duration for exposure to ethical challenges, as noted in similar studies) (1, 21)
- Being employed as contractual or permanent nursing staff
- Working in morning, evening, or night shifts
- Willingness to participate after the researcher explained the study objectives and methods
- Completion of the questionnaires

Exclusion Criteria:

- Working as a part-time nurse in internal or surgical wards
- Working in other wards
- Being on sick leave
- Being a newly-hired nurse
- Unwillingness to participate
- Failure to complete the questionnaires

The sample size was calculated using Cochran's formula, based on the prevalence of moral sensitivity and missed nursing care from previous studies (22), with P = 0.5, q = 0.5, Z = 1.96, and d = 0.05, resulting in a sample of 120 nurses. Accounting for a 10% dropout rate, 150 nurses were initially included.

Instruments

1. The Demographic Information Form: This form included 11 questions on age, gender, work experience, education level, work shift, employment status, marital status, military service, hospital, organizational position, and economic status.

2. The Moral Sensitivity Questionnaire: Developed by Lutzen et al. in 1994 in Sweden and later revised by Comrie (23), this questionnaire initially had 30 items, reduced to 25, assessing nurses' ethical decision-making in clinical practice. Each item is scored on a Likert scale: strongly agree (4), somewhat agree (3), somewhat disagree (2), strongly disagree (1), and no opinion (0). The total score ranges from 0 to

100, with scores of 0–50 indicating low, 51–75 moderate, and 76–100 high moral sensitivity. The questionnaire covers six dimensions: respect for patient autonomy, awareness of patient communication, professional knowledge, experience of ethical problems and conflicts, application of ethical concepts in decision-making, and honesty and benevolence (23). In Iran, its face and content validity were confirmed by Abbaszadeh et al., with a reliability of 0.81 (Cronbach's alpha) (24). In this study, the reliability was 0.89 (Cronbach's alpha).

3. The Missed Nursing Care Questionnaire: Developed by Kalisch in 2006 and psychometrically evaluated in 2009, this questionnaire includes 24 items. Each item is scored on a Likert scale: rarely missed (1), occasionally missed (2), frequently missed (3), and always missed (4). The total score ranges from 24 to 96, with higher scores indicating a greater likelihood of missed care (5). In Iran, its validity was confirmed by Khajooee et al. with a reliability of 0.89 (16). In this study, the reliability was 0.91 (Cronbach's alpha).

Data Collection

Data were collected from April to June 2024. The quota sampling method was employed to select the study population. To ensure proportional representation across the hospitals, the total number of nurses working in the medical and surgical wards of each hospital was determined. Based on the calculated sample size of 150, the number of nurses to be recruited from each hospital was allocated proportionally using the formula: (number of nurses in a hospital ÷ total number of

nurses across all hospitals) × 150. This ensured that each hospital contributed a sample size reflective of its nurse population. Within each hospital, random sampling was used to select individual nurses who met the inclusion criteria. To account for variability in work schedules and ensure representation across different times of the day, sampling was conducted across three shifts: morning, afternoon, and night. This approach helped capture a diverse range of nurses working under varying conditions.

The subgroups in this study were determined by hospital type and department (internal versus surgical) to reflect the organizational structure of teaching hospitals and distinct clinical settings. Each hospital was considered a subgroup to account for potential differences in workplace culture, resources, or patient populations that might affect ethical sensitivity or missed nursing care. In addition, nurses were stratified by

department type (internal versus surgical) within each hospital, as these departments may involve different nursing demands and ethical challenges. For example, internal departments often manage chronic illnesses, whereas surgical departments deal with acute postoperative care, which potentially affects nurses' ethical sensitivity or care delivery. Proportional allocation ensured that the sample from each hospital and department type was representative of the entire nursing population, and random sampling within these subgroups minimized selection bias.

To collect data, nurses who met the inclusion criteria were identified. They were informed about the purpose of the study and provided with a moral consent form to complete before receiving the questionnaire. They were assured that all information would remain confidential and inaccessible to unauthorized individuals. To further ensure compliance with ethical guidelines, the questionnaires were distributed anonymously, allowing nurses to complete and return them to the researchers without identifiable information.

Data Analysis

Data were entered into SPSS version 26 for analysis. Statistical tests included the independent t-test, Pearson's correlation coefficient, and chi-square test. Predictive value was assessed using regression analysis. Data normality was tested using the Kolmogorov-Smirnov test, with a significance level of $P > 0.05$ indicating normal data. Descriptive statistics (mean, standard deviation, median, etc.), correlation tests, linear regression, t-tests, and one-way ANOVA were used for analysis, with a significance level of $P < 0.05$.

Results

Of the 120 distributed questionnaires, 7 were excluded due to incomplete responses or non-return, leaving 113 questionnaires for analysis. The mean age and work experience of participants were 34.50 ± 16.7 years and 8.95 ± 7.11 years, respectively. Most participants were female (57.5%), held a bachelor's degree (94.2%), and were contractual employees (45.8%) (Table 1).

Table 1. Mean scores of moral sensitivities and its dimensions among nurses in internal and surgical wards in Urmia, 2024

Dimensions of Moral Sensitivity	Mean	Standard Deviation	Minimum Score	Maximum Score
Patient-centered care	3.86	0.542	1.5	4
Professional responsibility	3.70	0.50	1.43	3.71
Application of ethical concepts	3.14	0.80	0	3.75
Ethical problems and conflicts	3.11	0.80	0.25	3.75
Nurse-Patient communication	4.07	0.48	1.67	3.83
Honesty and beneficence	3.80	0.87	0	4
Total Moral Sensitivity	**76.45 ± 4.7**			

The mean moral sensitivity score was 76.45 ± 4.7, indicating a moderate level. The highest mean score pertained to the dimension of nurse-patient communication, and the lowest to honesty and benevolence (Table 1). The mean missed nursing care score was 46.45 ± 5.5, also at a moderate level. The highest mean score for missed care was related to "turning patients every two hours," and the lowest to "measuring vital signs as per physician orders" (Table 2).

Table 2. Mean scores of missed nursing care and care items among nurses in internal and surgical wards in Urmia, 2024

No.	Care Item	Mean ± SD
1	Turning patient every 2 hours	2.61 ± 1.35
2	Assisting with toileting within 15 minutes of request	1.93 ± 0.90
3	Attending interdisciplinary care conferences	1.87 ± 0.89
4	Mobilizing patient 3 times a day or as ordered	1.82 ± 1.04
5	Providing oral care	1.81 ± 0.72
6	Supervising or performing patient bathing and skin care	1.75 ± 0.82
7	Ensuring food is given to the patient before it gets cold	1.69 ± 0.75
8	Providing emotional support to patient and family	1.68 ± 0.68
9	Preparing food for patients who can eat independently	1.64 ± 0.71
10	Wound care	1.63 ± 0.77
11	Comprehensive patient assessment per shift	1.61 ± 1.26
12	Patient education at discharge	1.58 ± 0.72
13	Responding to call bell within 5 minutes	1.56 ± 0.83
14	Monitoring blood glucose	1.56 ± 0.75
15	Evaluating medication effectiveness	1.54 ± 0.68
16	Assessing and caring for peripheral and central lines	1.54 ± 0.70
17	Administering PRN medications within 15 minutes of request	1.52 ± 0.67
18	Patient education on illness, tests, and diagnostics	1.51 ± 0.70
19	Monitoring intake and output	1.51 ± 0.66
20	Focusing on reassessment based on patients' condition	1.49 ± 0.65
21	Handwashing before care	1.49 ± 0.63
22	Administering medications within 30 minutes of scheduled time	1.45 ± 0.62
23	Complete documentation of essential information	1.38 ± 0.58
24	Measuring vital signs as per physician orders	1.35 ± 0.59
Total Missed Nursing Care	**46.45 ± 5.5**	

A significant relationship was found between employment status and moral sensitivity, with permanent nurses showing higher moral sensitivity than others ($P < 0.05$) (Table 3). Education level was significantly associated with missed nursing care, that is, nurses who had a bachelor's degree reported more missed care than those with a master's degree or higher ($P < 0.05$). Additionally, shift type was significantly related to missed nursing care, with rotating-shift nurses reporting more missed care than fixed-shift nurses (Table 3).

Table 3. Relationship between demographic characteristics, moral sensitivity, and missed nursing care

Variable		Frequency	Percentage	Moral Sensitivity (mean ± SD)	Missed Nursing Care (mean ± SD)
Gender	Male	51	42.5	76.45 ± 7.31	46.12 ± 7.42
	Female	69	57.5	76.33 ± 6.79	46.45 ± 8.48
	***P*-Value**			$P = 0.45$	$P = 0.5$
Academic Degree	Bachelor's degree	113	94.2	76.88 ±6.89	47.97 ± 9.08
	Master's degree and higher	7	5.8	76.13 ±6.06	46.46 ± 10.66
	***P*-Value**			$P = 0.2$	$P = 0.5$
Employment Status	Formal contract	29	24.2	77.78 ± 9.47	45.23 ± 9.07
	Permanent contract	21	17.5	76.99 ± 7.73	46.99 ± 5.53
	Fixed-Term contract	55	45.8	76.13 ± 8.84	46.78 ± 4.12
	***P*-Value**			*$P = 0.01$*	$P = 0.4$
Work Shift	Fixed	20	33.3	75.05 ± 6.63	46.78 ± 4.12
	In rotation	100	66.7	75.64 ± 6.63	48.78 ± 4.12
	***P*-Value**			$P = 0.4$	*$P = 0.01$*
Organizational Chart	Head nurse	23	19.2	76.78 ± 9.14	46.23 ± 5.07
	Nurse	97	80.3	76.33 ± 9.47	46.23 ± 9.65
	***P*-Value**			$P = 0.1$	$P = 0.1$
Hospital Name	Kowsar	27	18	75.50 ± 4.97	46.46 ± 8.63
	Imam Khomeyni	56	37.3	77.55 ± 6.64	47.84 ± 9.24
	Taleghani	23	15.3	76.13 ± 6.93	45.00 ± 7.26
	Motahari	44	29.3	76.18 ± 6.95	46.24 ± 10.47
	***P*-Value**			$P = 0.2$	$P = 0.5$

Pearson's correlation test revealed a significant inverse relationship between moral sensitivity and missed nursing care, indicating that higher moral sensitivity was associated with lower missed nursing care ($r = -0.25$, $P < 0.001$) (Table 4).

Table 4. Prediction of missed nursing care based on moral sensitivity

Variable	Unstandardized Coefficient	Standardized Coefficient	t	*P*-Value
Moral Sensitivity	8.11	-0.25	9.94	< 0.001
Work Shift	7.26	0.33	8.33	< 0.001

Discussion

This research aimed to examine the connection between moral sensitivity and instances of missed nursing care among nurses in medical and surgical units. The correlation analysis revealed a significant relationship between moral sensitivity scores and missed nursing care, indicating that as nurses' moral sensitivity increased, the incidence of missed nursing care decreased. Previous research has investigated the relationship between moral sensitivity and nurses' compassionate acts, care quality, adherence to patients' rights, or ethical conduct, yielding varied results. For example, Farasatkish et al. observed that the majority of nurses displayed moderate levels of moral sensitivity and compassionate behavior, but found no notable link between the two (25). On the other hand, nurses demonstrating higher regard for patient autonomy had attended more medical ethics seminars or workshops (25). Similarly, Amiri et al. found no significant relationship between nurses' moral sensitivity scores and quality of care scores (27). In contrast, Mahdiyoun et al. examined the correlation between nurses' moral sensitivity and respect for patients' rights, reporting moderate levels of both and a positive correlation between the two variables (26). While these studies did not explicitly examine the connection between moral sensitivity and missed nursing care, it can be inferred that caring behaviors and care quality are linked to missed nursing care. Variations in study findings may stem from differences in methodology and contextual influences. Thus, future research should directly investigate the link between moral sensitivity and missed nursing care.

In this study, nurses' moral sensitivity was at a moderate level, with the dimension of nurse-patient communication scoring the highest, and the dimension of experiencing ethical dilemmas and conflicts the lowest. The results also showed an association between moral sensitivity and the demographic variable of employment status. Studies by Hashmatifar et al. and Amiri et al.

reported moderate levels of moral sensitivity among nurses, which is consistent with the findings of the present study (15, 27). Moreover, Kim et al. noted that nurses generally possess a sense of responsibility and moral sensitivity, but the key difference lies in their adherence to this sensitivity in challenging situations (31). In this study, the highest score was related to the dimension of awareness of interpersonal communication, aligning with findings from Amiri, Borhani, and Farasatkish (27, 28, 25). Given the recent emphasis on patient communication in numerous workshops and seminars on nursing care, nurses tend to score higher in this area. Conversely, the lowest score was in the dimension of experiencing ethical dilemmas and conflicts, consistent with studies by Izadi and Amiri (29, 27). In this regard, most nurses reported encountering situations where they were unsure which action was ethically appropriate for a specific patient. Studies also indicate that while many nurses are aware of ethical challenges, they often do not act on them due to the lack of sufficient authority, support, or knowledge of appropriate ethical solutions, which is a common issue in their work environment.

Additionally, this study found a significant positive correlation between nurses' work experience and moral sensitivity. Arslan study also reported a positive correlation between nurses' age, work experience, and overall moral sensitivity scores (30). Kim et al. noted that nurses aged 25 to 30 exhibited higher moral sensitivity than those younger than 25 or older than 30 (31). It appears that with increased age and work experience, nurses’ professional and communication skills improve, as does their awareness of their supportive and effective role in care, leading to enhanced moral sensitivity.

The findings of this study showed that the average level of missed nursing care in the participating units was moderate, consistent with studies by Ebadi et al. and Khajoei et al. (32, 22). The highest incidence of missed nursing care in the evaluation domain was related to “focusing on patient reassessment based on their condition.” In contrast, Zelenikova et al. found that “incomplete documentation of essential information in patient records” was the most frequent missed care (33). The findings also indicated that in the domain of interventions addressing individual needs, the most missed nursing care was “emotional support for patients and their families,” consistent with studies

conducted in Korean and the Czech Republic (31, 34). Diab et al. identified "responding to a patient's call bell within five minutes" as the most missed nursing care in this domain (35).

In this study, the most missed nursing care in the domain of basic care interventions was "monitoring patients' food intake before it gets cold," aligning with Diab et al.'s findings (35). In contrast, Arslan et al. reported "patient mobility and repositioning" (30), and Khajoei et al. noted "monitoring food preparation for patients unable to eat independently" as the most missed care (22). The findings also showed that the most missed nursing care in the planning domain was "participation in interdisciplinary care conferences," consistent with results from Kalisch et al. (34), Khajoei et al. (22), Chegini et al. (1), and Diab et al. (35). These findings may be explained by nurses' tendency not to prioritize such care as essential tasks. Missed care such as monitoring food intake or providing emotional support to patients and families, which were among the most frequent in this study, may result from insufficient understanding of their importance and a shortage of nursing staff, leading nurses to prioritize more urgent tasks. Lack of participation in interdisciplinary care conferences could be attributed to the absence of structured schedules aligned with nurses' varying shifts, the perceived unimportance of such conferences, and inadequate oversight by hospitals regarding adherence to the latest care standards. Additionally, this study found a relationship between work shift and missed nursing care. It appears that disruptions in nurses' circadian rhythms and sleep cycles lead to physical and mental fatigue, reducing cognitive and functional performance and consequently increasing the incidence of missed nursing care.

Data were based on self-reports, which may introduce bias. Future studies could use observational methods or checklists for evaluation. Potential low participation was addressed by clearly explaining the study objectives to encourage cooperation.

Conclusion

These findings underscore the critical role of moral sensitivity in promoting ethical decision-making and improving patient care quality, thereby mitigating risks to patient safety, satisfaction, and recovery. By fostering moral sensitivity, healthcare systems can address underlying contributors to missed care, such as resource constraints and ethical dilemmas,

ultimately enhancing overall nursing performance and healthcare outcomes. To translate these insights into practice, nursing managers and policymakers should prioritize interventions aimed at bolstering moral sensitivity, including targeted in-service training programs, ethical workshops, role modeling by senior staff, and development of clear ethical guidelines. Furthermore, systemic improvements such as optimizing staffing ratios, stabilizing work shifts, and enhancing compensation could alleviate workload pressures and further reduce missed care. Future research should explore longitudinal designs and observational methods to validate these relationships and examine interventions in diverse settings, ensuring broader applicability across global healthcare contexts.

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Conflict of Interests

The authors declare no conflicts of interests.

Ethics Considerations

The study was approved by the research committee of Urmia University of Medical Sciences (Ethics Code: IR.UMSU.REC.1403.227). Necessary permissions were obtained, and informed verbal and written consent was secured from all participants. The study objectives, methods, and confidentiality measures were explained, and participants' questions were addressed.

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