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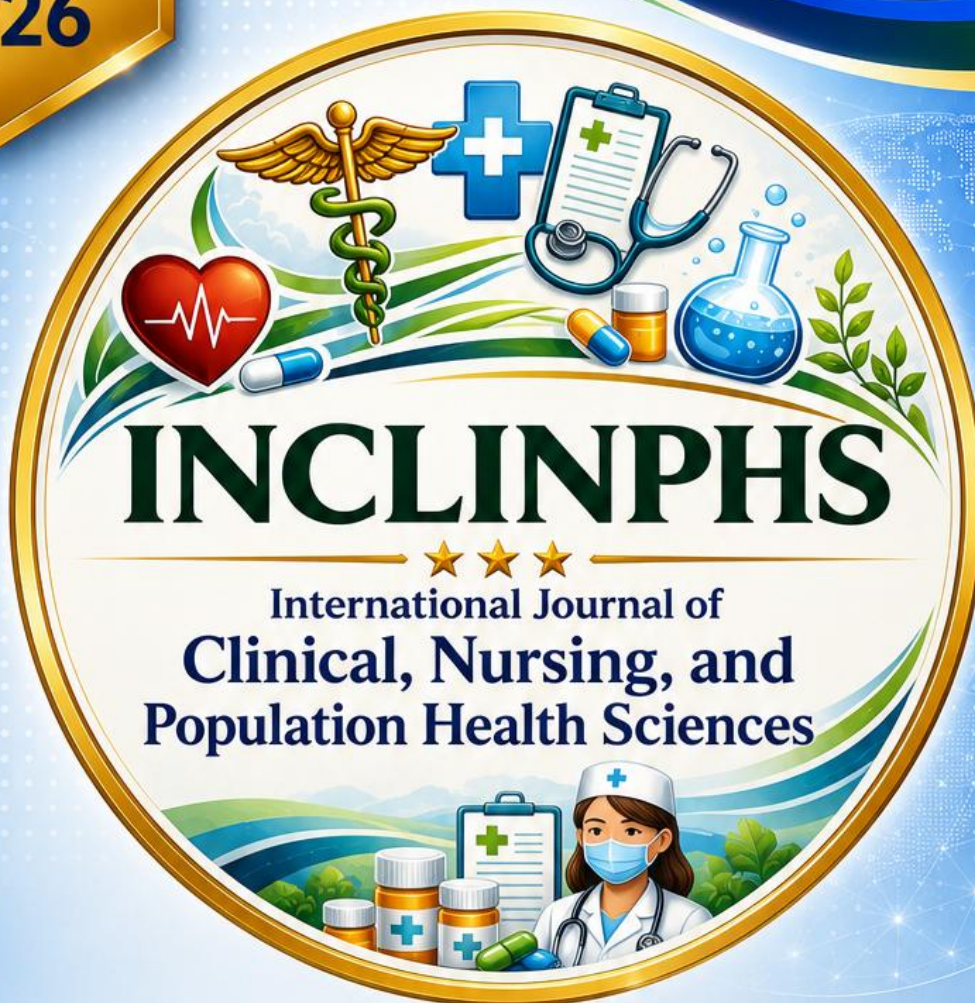
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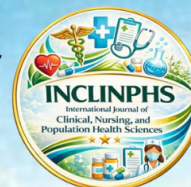
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Do moral sensitivity and clinical reasoning differentiate missed nursing care? A cross-sectional comparative study

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Abstract

Aim: This study examined the levels of moral sensitivity, clinical reasoning, and missed nursing care among hospital nurses and compared missed nursing care according to moral sensitivity level, clinical reasoning level, and their combination to generate evidence for improving nursing practice and patient safety.

Methods: A descriptive-comparative, cross-sectional design was employed involving 211 staff nurses from two tertiary hospitals in Valenzuela City, Metro Manila, Philippines. Data were collected using the Moral Sensitivity Questionnaire-Revised (Lützen et al., 2006), the Clinical Reasoning Competency Scale (Bae et al., 2023), and the MISSCARE Survey Part A (Kalisch & Williams, 2009). Independent samples *t*-tests and two-way analysis of variance were performed at $\alpha = .05$, with Cohen's *d* and partial eta-squared used as measures of effect size.

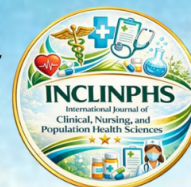
Results: Moral sensitivity was moderately high ($M = 4.23$, $SD = 0.64$), clinical reasoning was high ($M = 3.85$, $SD = 0.43$), and missed nursing care was generally rated as rarely missed ($M = 3.46$, $SD = 0.45$), although nine of the 24 nursing care activities were classified as occasionally missed. Nurses with high moral sensitivity demonstrated significantly lower levels of missed nursing care than those with low moral sensitivity, $t(209) = 4.21$, $p < .001$, $d = 0.59$. Likewise, nurses with high clinical reasoning reported significantly less missed nursing care than those with low clinical reasoning, $t(209) = 4.94$, $p < .001$, $d = 0.68$. Two-way analysis of variance revealed significant main effects of clinical reasoning, $F(1, 207) = 16.83$, $p < .001$, $\eta^2 = .075$, and moral sensitivity, $F(1, 207) = 10.30$, $p = .002$, $\eta^2 = .047$, with no significant interaction effect ($F(1, 207) = 0.14$, $p = .712$).

Conclusion: Moral sensitivity and clinical reasoning independently contribute to reducing missed nursing care through distinct ethical and cognitive pathways. Strengthening both competencies through targeted professional development may enhance nursing performance, improve patient safety, and support higher-quality healthcare delivery in hospital settings.

Keywords: moral sensitivity, clinical reasoning, missed nursing care, hospital nurses, patient safety, nursing practice, Philippines

INTRODUCTION

Missed nursing care — the omission, delay, or incomplete delivery of required patient care — has been recognized as a significant threat to patient safety in hospital settings worldwide (Kalisch & Williams, 2009). While structural determinants such as inadequate staffing, high patient acuity, and resource scarcity are well established as drivers of care omissions, recent research attention has turned toward nurse-level attributes that may independently influence whether care is completed or missed. Among these, two constructs have gained particular relevance: moral sensitivity, defined as the nurse's capacity to recognize the ethical dimensions of clinical situations and the potential consequences of decisions for patients (Lützen et al., 2006); and clinical reasoning, the cognitive process through which nurses collect, interpret, and act on patient data to arrive at sound clinical judgments (Tanner, 2006).



Although both capacities are individually recognized as essential to safe, patient-centered care, the extent to which they jointly or separately differentiate nurses who miss care from those who do not has not been empirically tested.

The Philippine healthcare system presents a particularly relevant context for investigating these relationships. The country faces a shortage of approximately 127,000 nurses, with nurse-to-patient ratios in public hospitals reaching 1:20 and escalating to 1:50 — far exceeding the Department of Health's 1:12 standard (Alibudbud, 2023; Tamayo et al., 2022). Chronic understaffing is compounded by low wages, job insecurity, and a sustained exodus of Filipino nurses to Organisation for Economic Co-operation and Development (OECD) countries (Alibudbud, 2023). Within this workforce environment, Tamayo et al. (2022) documented nursing care rationing in a Philippine tertiary public hospital and found that the nurse practice environment was significantly associated with the extent to which nurses rationed care activities. These conditions make Filipino hospital nurses a critical but understudied population for examining how moral sensitivity and clinical reasoning relate to missed care.

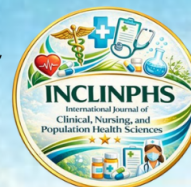
Despite growing international interest in these constructs, three gaps persist in the literature. First, while a small number of studies have examined the relationship between moral sensitivity and missed nursing care, clinical reasoning has not been included as a concurrent variable in any missed care study — leaving the cognitive dimension unaccounted for alongside the ethical. Second, no study has tested whether the combination of moral sensitivity and clinical reasoning levels differentiates the extent of missed care, which limits understanding of how these capacities interact. Third, while missed nursing care has received limited attention in the Philippine context (Labrague et al., 2022), no Philippine study has examined moral sensitivity or clinical reasoning among hospital nurses, and no study — Philippine or international — has investigated all three constructs within a single comparative design.

This study aimed to determine the levels of moral sensitivity, clinical reasoning, and missed nursing care among hospital nurses in selected tertiary hospitals in Valenzuela City, Metro Manila, and to compare missed nursing care when respondents are grouped according to level of moral sensitivity, level of clinical reasoning, and the combination of both. Specifically, the study sought to: (1) describe the demographic and professional profile of respondents; (2) determine the level of moral sensitivity; (3) determine the level of clinical reasoning in terms of plan setting, intervention strategy regulation, and self-instruction; (4) determine the extent of missed nursing care; (5) test for significant difference in missed nursing care by moral sensitivity level; (6) test for significant difference in missed nursing care by clinical reasoning level; (7) test for significant difference in missed nursing care by the combined levels of moral sensitivity and clinical reasoning; and (8) propose a competency development matrix based on the findings. The study contributed to the missed nursing care literature by introducing clinical reasoning as a comparative variable alongside moral sensitivity, testing their combined effect on care completion, and extending this line of inquiry to the Philippine context. Reducing missed nursing care carries implications beyond the individual patient: because omitted care contributes to preventable complications, longer stays, and diminished quality of care, lowering its occurrence improves population-level health outcomes and health-system performance. These findings are positioned to inform nursing workforce planning, competency standards, nursing education policy, and hospital quality-improvement programs, in addition to their contribution to nursing science.

Review of Related Literature and Studies

Moral Sensitivity and Clinical Reasoning in Nursing Practice

Moral sensitivity and clinical reasoning represent two distinct but complementary cognitive-moral capacities that shape how nurses perceive ethical demands and process clinical information in practice. Moral sensitivity, as conceptualized by Lützen et al. (2006), refers to the nurse's capacity to recognize the moral dimensions of care situations, including awareness of patient vulnerability, the potential for harm, and the weight of professional responsibility in clinical decisions. A recent systematic review and meta-analysis of 99 studies involving 29,387 nurses reported moderate overall moral sensitivity levels among nurses, with significant variation across clinical settings and geographic regions (Zhao et al., 2025). Nurses with higher moral sensitivity tend to experience greater attunement to patient needs but are also more vulnerable to moral distress when institutional constraints prevent ethically congruent action (Kovancı & Atlı Özbaş, 2024). Clinical reasoning, on the other hand, operates as the cognitive process through which nurses collect, interpret, and prioritize patient data to arrive at sound clinical judgments — a process central to Tanner's (2006) Clinical Judgment Model, which identifies noticing, interpreting, responding, and reflecting as its four iterative phases. The Clinical Reasoning Competency Scale (CRCS), developed by Bae et al. (2023) and validated cross-culturally by Mohammadi et al. (2024), operationalizes this process across three dimensions: plan setting, intervention strategy regulation, and self-instruction. A bibliometric analysis of 1,528 studies confirmed that clinical reasoning and clinical judgment remain among the most actively researched competencies in nursing, yet their measurement in practicing nurses — as opposed to students in simulation settings



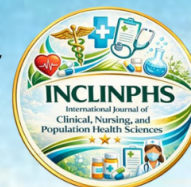
— remains underdeveloped (Doyon & Raymond, 2025). While both moral sensitivity and clinical reasoning are recognized individually as essential to safe, patient-centered care, they are rarely examined together despite occupying overlapping conceptual terrain: the nurse who notices a patient's unspoken distress exercises moral sensitivity, and the nurse who interprets deteriorating vital signs exercises clinical reasoning, yet both capacities converge in the moment a clinician decides whether, when, and how to act.

Missed Nursing Care — Scope, Prevalence, and Determinants

Missed nursing care — defined by Kalisch and Williams (2009) as any aspect of required patient care that is omitted or significantly delayed — has emerged as a critical indicator of care quality with direct consequences for patient safety. A systematic review and meta-analysis encompassing 28 studies across 14 countries found that the prevalence of missed care ranged from 6.8% to 98.1%, with ambulation, mouth care, and patient education among the most frequently omitted activities; the most commonly reported drivers were unexpected surges in patient volume, inadequate staffing, and urgent competing demands (Gong et al., 2025). These structural antecedents are compounded in low- and middle-income settings, where Imam et al. (2023) documented that resource scarcity, high patient-to-nurse ratios, and weak organizational infrastructure amplify the frequency and scope of care omissions beyond what is typically reported in high-income contexts. The Philippine nursing workforce exemplifies these compounding pressures: chronic understaffing, wages as low as ₱8,000 monthly in private hospitals, mass resignations accelerated by the pandemic, and a nurse-to-population ratio well below the World Health Organization (WHO) benchmark of 27 per 10,000 create working conditions in which care omissions become structurally embedded rather than incidental (Alibudbud, 2023). Among Filipino frontline nurses during COVID-19, patient surveillance, comfort measures, and skin care were the most frequently missed activities, with staffing levels and patient safety culture emerging as the strongest predictors of missed care (Labrague et al., 2022). Downstream, these omissions carry measurable consequences: a meta-analysis of 85 studies confirmed that nurse burnout — itself fueled by the same resource constraints that drive missed care — is associated with increased medication errors, higher infection rates, and lower patient satisfaction (Li et al., 2024). What remains less understood is whether nurse-level cognitive and moral attributes — beyond the well-documented structural and organizational determinants — independently contribute to the occurrence of missed care.

Linking Moral-Cognitive Capacities to Care Omissions — Evidence and Gaps

Emerging evidence suggests that moral sensitivity may function as a nurse-level protective factor against care omissions, though the evidence base remains small and geographically concentrated. Among ICU nurses in Iran, Nobahar et al. (2023) found that higher moral sensitivity negatively predicted missed nursing care and that teamwork functioned as a concurrent positive predictor of moral sensitivity — a pattern replicated by Jia et al. (2025) among Chinese ICU nurses, who further demonstrated that shift length and employment type independently influenced missed care frequency. In a study of new nurses with less than two years of experience, Xu et al. (2025) reported a significant inverse relationship between moral sensitivity and missed care, with both variables contributing to moral distress, suggesting a cyclical dynamic in which care omissions erode the very moral awareness needed to prevent them. The direction of this relationship, however, is not uniform: Ahansaz et al. (2024) found no significant bivariate correlation between moral sensitivity and missed care among Iranian medical-surgical nurses, though regression analysis controlling for demographic and work-condition variables revealed moral sensitivity as a significant predictor — indicating that the relationship may be obscured when structural confounders are not accounted for. A mediation study by Taskiran Eskici et al. (2025) advanced this line of inquiry further by demonstrating that moral sensitivity partially mediated the effect of professional values on missed nursing care (indirect effect $\beta = -0.172$), positioning moral sensitivity not merely as a correlate but as a mechanism through which broader professional orientations translate into care delivery behaviors. Notably absent from this growing literature is any examination of clinical reasoning as a concurrent factor. While Jessee (2021) established that deficits in clinical judgment are directly implicated in failure-to-rescue events and missed or delayed care, no published study has examined whether clinical reasoning competency — the cognitive counterpart to moral sensitivity's ethical attunement — independently or jointly differentiates nurses who miss care from those who do not. This gap is particularly consequential in the Philippine context, where no study has investigated moral sensitivity, clinical reasoning, or missed nursing care among Filipino hospital nurses using validated instruments, despite workforce conditions that make care omissions a pressing patient safety concern. The present study addresses this gap by comparing the extent of missed nursing care across combined levels of moral sensitivity and clinical reasoning among hospital nurses in the Philippines.



Synthesis

Taken together, the reviewed literature establishes that moral sensitivity and clinical reasoning are individually linked to care quality and patient safety, yet remain siloed in research — moral sensitivity studied alongside missed care in a handful of cross-sectional designs concentrated in Iran and China, clinical reasoning examined almost exclusively in educational or simulation contexts rather than in relation to actual care delivery outcomes. No study has examined whether the combination of these two capacities differentiates the extent of missed nursing care, and no empirical data exist on any of these three constructs among Filipino hospital nurses. The present study addresses both gaps by comparing missed nursing care across levels of moral sensitivity, clinical reasoning, and their interaction among staff nurses in selected Philippine hospitals.

Theoretical Framework

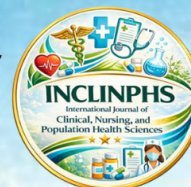
This study was anchored in two complementary frameworks: Rest's Four-Component Model of moral behavior (Rest, 1983) and Tanner's Clinical Judgment Model (Tanner, 2006). Rest's model addressed the ethical dimension of the study, while Tanner's model addressed the cognitive dimension. Together, they provided a unified theoretical basis for examining how moral sensitivity and clinical reasoning — one ethical, one cognitive — related to the occurrence of missed nursing care.

Rest (1983) proposed that moral behavior results from four interrelated psychological processes: moral sensitivity — the capacity to recognize that a situation has ethical implications and that one's actions may affect the well-being of others; moral judgment — the ability to determine which course of action is morally right; moral motivation — the willingness to prioritize ethical values over competing self-interests; and moral character — the strength to follow through on moral intentions despite obstacles. Of these four components, moral sensitivity served as the entry point: without recognizing that a care situation carried ethical weight, the subsequent processes of judging, prioritizing, and acting could not be activated. Lützen et al. (2006) drew on this tradition in developing the concept of moral sensitivity for nursing, defining it as the nurse's awareness of the ethical dimensions of care decisions, the vulnerability of patients, and the potential consequences of professional actions. The MSQ-R, used in this study, operationalized this first component of Rest's model. The framework thus provided the theoretical rationale for treating moral sensitivity as a nurse-level attribute that preceded and shaped care decisions — and for hypothesizing that nurses with differing levels of moral sensitivity might differ in the extent of their missed care.

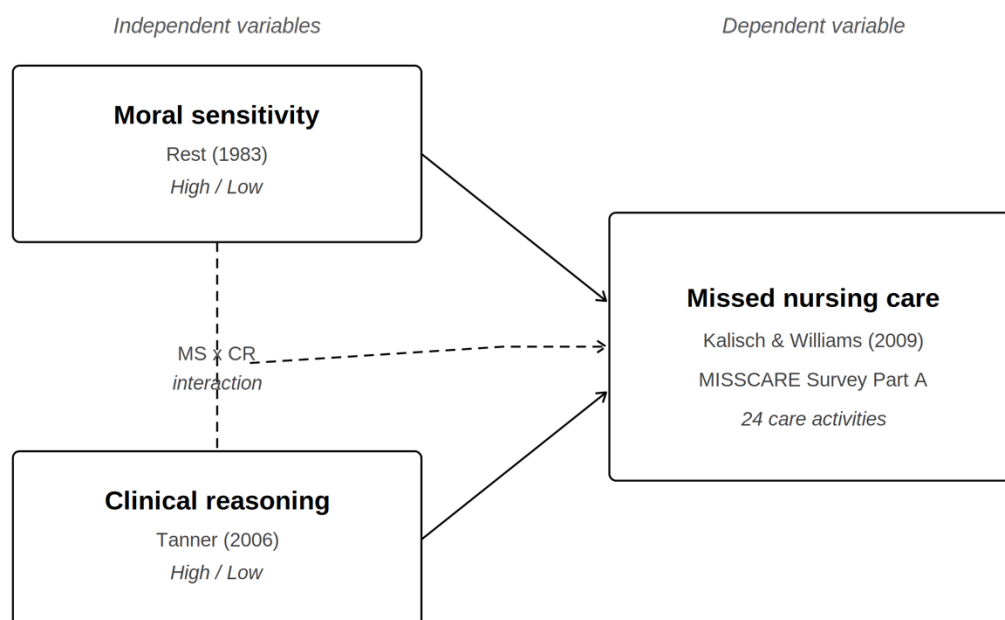
Tanner (2006) developed the Clinical Judgment Model from a synthesis of nearly 200 studies on how nurses think in clinical practice. The model identified four iterative phases: noticing — the perceptual grasp of a situation shaped by the nurse's expectations, knowledge, and relationship with the patient; interpreting — the analysis of collected data to develop understanding; responding — the selection and implementation of appropriate nursing actions; and reflecting — the critical review of actions and outcomes, occurring both during care and after the event. Tanner drew five conclusions from the evidence base: clinical judgments are influenced more by what nurses bring to the situation than by objective data alone; sound judgment depends on knowing the patient; the context and culture of the nursing unit shape judgment; nurses employ multiple reasoning patterns; and reflection is essential for clinical knowledge development. The CRCS (Bae et al., 2023), used in this study, operationalized the cognitive processes embedded in Tanner's phases: plan setting corresponded to noticing and interpreting, intervention strategy regulation to responding, and self-instruction to reflecting. The model thus provided the theoretical basis for examining whether nurses with differing clinical reasoning competencies also differed in the extent of their missed care.

The two frameworks converged on the dependent variable. Rest's model explained *why* a nurse might miss care — a failure of moral sensitivity meant the ethical demand of the care situation was not recognized, and the motivation to act on the patient's behalf was not activated. Tanner's model explained *how* a nurse might miss care — a breakdown at any phase of clinical judgment meant that a care need was not noticed, not correctly interpreted, not acted upon, or not reflected upon for future prevention. Missed nursing care, as conceptualized by Kalisch and Williams (2009), represented the observable outcome when either or both of these processes failed. The present study tested whether nurses grouped by moral sensitivity level (Rest), clinical reasoning level (Tanner), and their combination differed in the extent of missed care — thereby operationalizing the intersection of the two frameworks.

Figure 1 illustrates the conceptual framework guiding this study. Moral sensitivity, grounded in Rest's (1983) Four-Component Model, and clinical reasoning, grounded in Tanner's (2006) Clinical Judgment Model, serve as independent variables, each dichotomized into High and Low groups by median split. Missed nursing care, measured by the MISSCARE Survey Part A (Kalisch & Williams, 2009), serves as the dependent variable. The solid arrows represent the hypothesized group differences tested individually: nurses grouped by moral sensitivity level were



compared on the extent of missed nursing care (RQ5), and nurses grouped by clinical reasoning level were compared similarly (RQ6), both using independent samples *t*-tests with Cohen's *d*. The dashed arrow represents the combined comparison (RQ7), in which missed nursing care was examined across four subgroups formed by the combination of moral sensitivity and clinical reasoning levels (High moral sensitivity [MS]–High clinical reasoning [CR], High MS–Low CR, Low MS–High CR, Low MS–Low CR) using a two-way ANOVA with partial eta-squared as the effect size measure. The framework operationalized the intersection of Rest's ethical pathway and Tanner's cognitive pathway, testing whether each independently—and in combination—differentiated the extent of care omissions among hospital nurses.



Statement of the Problem

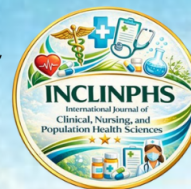
Missed nursing care has become a significant patient safety concern because omissions or delays in essential nursing interventions may adversely affect patient outcomes, quality of care, and healthcare service delivery. Although previous international studies have demonstrated that moral sensitivity is associated with missed nursing care, little is known about the role of clinical reasoning as a concurrent factor influencing care omissions. Moreover, no published study has simultaneously examined moral sensitivity, clinical reasoning, and missed nursing care among Filipino hospital nurses using a comparative design. Addressing these gaps is essential for developing evidence-based competency development strategies that strengthen nursing practice and improve patient safety.

This study therefore sought to determine the levels of moral sensitivity, clinical reasoning, and missed nursing care among hospital nurses in selected tertiary hospitals in Valenzuela City, Metro Manila, Philippines, and to compare missed nursing care according to nurses' levels of moral sensitivity, clinical reasoning, and the combination of these competencies.

Objectives

This study aimed to determine the levels of moral sensitivity, clinical reasoning, and missed nursing care among hospital nurses in selected tertiary hospitals in Valenzuela City, Metro Manila, and to compare missed nursing care when grouped according to level of moral sensitivity, level of clinical reasoning, and the combination of both. Specifically, this study sought to:

1. Describe the demographic and professional profile of the respondents in terms of age, sex, highest educational attainment, years of clinical nursing experience, current unit/ward assignment, employment status, and average number of patients handled per shift;
2. Determine the level of moral sensitivity among the respondents;
3. Determine the level of clinical reasoning among the respondents in terms of plan setting, intervention strategy regulation, and self-instruction;



4. Determine the extent of missed nursing care among the respondents;
5. Compare missed nursing care when respondents were grouped according to their level of moral sensitivity;
6. Compare missed nursing care when respondents were grouped according to their level of clinical reasoning;
7. Compare missed nursing care when respondents were grouped according to the combined levels of moral sensitivity and clinical reasoning; and
8. To develop a competency development matrix designed to reduce missed nursing care among hospital nurses based on the study findings.

All hypotheses were tested at a 0.05 level of significance.

H₀₁: There was no significant difference in missed nursing care when respondents were grouped according to their level of moral sensitivity.

H₀₂: There was no significant difference in missed nursing care when respondents were grouped according to their level of clinical reasoning.

H₀₃: There was no significant difference in missed nursing care when respondents were grouped according to the combined levels of moral sensitivity and clinical reasoning.

Research Questions

1. What was the demographic and professional profile of the respondents in terms of age, sex, highest educational attainment, years of clinical nursing experience, current unit/ward assignment, employment status, and average number of patients handled per shift?
2. What was the level of moral sensitivity among the respondents?
3. What was the level of clinical reasoning among the respondents in terms of plan setting, intervention strategy regulation, and self-instruction?
4. What was the extent of missed nursing care among the respondents?
5. Was there a significant difference in missed nursing care when respondents were grouped according to their level of moral sensitivity?
6. Was there a significant difference in missed nursing care when respondents were grouped according to their level of clinical reasoning?
7. Was there a significant difference in missed nursing care when respondents were grouped according to the combined levels of moral sensitivity and clinical reasoning?
8. Based on the findings, what competency development matrix may be developed to reduce missed nursing care among hospital nurses?

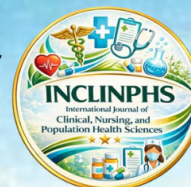
METHODS

Research Design

This study employed a descriptive-comparative, cross-sectional research design. A descriptive-comparative design is used to describe variables of interest and to compare outcomes across groups that differ on a naturally occurring characteristic, without manipulating any variable (Polit & Beck, 2021). The design was appropriate for this study because the objectives required describing the levels of moral sensitivity, clinical reasoning, and missed nursing care (descriptive component) and comparing missed nursing care across groups formed by moral sensitivity level, clinical reasoning level, and their combination (comparative component). The cross-sectional approach was suited to the study's aim of capturing data at a single point in time from a defined population of hospital nurses. No causal inferences were drawn; the study examined group differences in missed nursing care based on pre-existing attribute classifications (high/low moral sensitivity and clinical reasoning), consistent with the non-experimental nature of the design.

Population and Sampling

The respondents of this study were staff nurses employed in two selected tertiary hospitals in Valenzuela City, Metro Manila — one government and one private institution. The combined nursing workforce of both hospitals totaled 393. However, not all nurses were eligible for inclusion. The following inclusion criteria were applied: (a) registered nurse with a valid Philippine nursing license; (b) currently employed as a staff nurse in a direct patient care capacity; (c) at least six months of clinical nursing experience in the current hospital; and (d) assigned to an inpatient or acute care unit such as medical-surgical, pediatric, obstetric, intensive care, or emergency department. Excluded from the study were nurses holding administrative, supervisory, or managerial positions (head nurses, chief



nurses, nurse managers); those on extended leave of absence (maternity, medical, or study leave) during the data collection period; float or agency nurses without a permanent unit assignment; and nurses assigned exclusively to outpatient or ancillary departments where the direct inpatient care activities measured by the MISSCARE Survey were not routinely performed.

Applying these inclusion and exclusion criteria to the 393-member combined workforce reduced the pool to 250 staff nurses, who comprised the eligible population from which the census was drawn. Total population sampling was employed, wherein all eligible staff nurses were invited to participate. This approach was adopted for two reasons: first, the eligible population was finite, identifiable, and accessible within two hospital sites, making census methodologically appropriate and logistically feasible (Polit & Beck, 2021); and second, the two-way ANOVA required in RQ7 necessitated adequate cell sizes across four subgroups formed by the median split of moral sensitivity and clinical reasoning (High MS–High CR, High MS–Low CR, Low MS–High CR, Low MS–Low CR), and maximizing the respondent pool reduced the risk of underpowered cells from uneven group distributions. Of the 250 invited, 211 returned complete and usable questionnaires, yielding a response rate of 84.4%.

Instruments

Data were collected using a four-part self-administered questionnaire. Part I gathered the demographic and professional profile of respondents across seven items: age, sex, highest educational attainment, years of clinical nursing experience, current unit/ward assignment, employment status, and average number of patients handled per shift.

Part II measured moral sensitivity using the Moral Sensitivity Questionnaire–Revised (MSQ-R) developed by Lützen et al. (2006). The MSQ-R is a 9-item instrument rated on a 6-point Likert scale (1 = Totally Disagree to 6 = Totally Agree) with no reverse-scored items. The total score was computed as the mean of all items (range: 1.00–6.00), with higher scores indicating greater moral sensitivity. Published reliability coefficients range from $\alpha = 0.73$ to 0.87 across validation studies. The instrument was adopted as-is and is openly accessible with no permission required. Scores were interpreted as follows: 1.00–1.83 = Very Low, 1.84–2.67 = Low, 2.68–3.50 = Moderately Low, 3.51–4.33 = Moderately High, 4.34–5.17 = High, and 5.18–6.00 = Very High. For comparative analysis, respondents were classified into High and Low moral sensitivity groups using a median split of total scores.

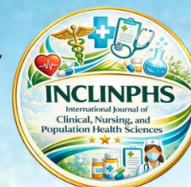
Part III measured clinical reasoning using the Clinical Reasoning Competency Scale (CRCS) developed by Bae et al. (2023). The CRCS is a 22-item instrument rated on a 5-point Likert scale (1 = Not at All to 5 = Always) with no reverse-scored items. It comprises three subscales: plan setting (8 items), intervention strategy regulation (11 items), and self-instruction (3 items). Subscale and total scores were computed as means, with higher scores indicating higher clinical reasoning competency. The original study reported an overall Cronbach's alpha of 0.92, and the scale was cross-culturally validated among critical care nurses by Mohammadi et al. (2024). The CRCS was adopted as-is under a CC BY 4.0 license. Scores were interpreted as: 1.00–1.80 = Very Low, 1.81–2.60 = Low, 2.61–3.40 = Moderate, 3.41–4.20 = High, and 4.21–5.00 = Very High. A median split of total scores classified respondents into High and Low clinical reasoning groups.

Part IV measured missed nursing care using Part A of the MISSCARE Survey developed by Kalisch and Williams (2009). This section contains 24 nursing care elements rated on a 5-point Likert scale (1 = Always Missed to 5 = Never Missed) with no reverse-scored items. The total score was computed as the mean of all items, with lower scores indicating a greater extent of missed care. Published reliability coefficients range from $\alpha = 0.86$ to 0.93. The instrument was adopted as-is with permission obtained from the author. Scores were interpreted as: 1.00–1.80 = Always Missed, 1.81–2.60 = Frequently Missed, 2.61–3.40 = Occasionally Missed, 3.41–4.20 = Rarely Missed, and 4.21–5.00 = Never Missed.

All three instruments were adopted without modification. The complete questionnaire comprised 55 core items plus 7 demographic items (62 items total), with an estimated completion time of 15–20 minutes.

Data Collection

Permission to conduct the study was secured from the chief of hospital or medical director of each participating institution. Upon institutional approval, the researcher coordinated with each hospital's nursing service office to identify eligible respondents. Data were collected from April 13 to April 30, 2026. Participants were briefed on the study, signed the informed consent form, and completed the 62-item self-administered questionnaire on-site in approximately 15–20 minutes. Completed questionnaires were collected in sealed envelopes. Data storage, retention, and disposal procedures are described under Ethical Considerations to avoid duplication.



Treatment of Data

All returned questionnaires were checked for completeness, coded, and encoded into SPSS version 26. Normality was assessed using the Shapiro-Wilk test and homogeneity of variance using Levene's test to determine whether parametric or non-parametric tests were appropriate. All hypotheses were tested at a 0.05 level of significance. Descriptive statistics — frequency counts, percentages, means, and standard deviations — were used to describe the respondents' demographic and professional profile (RQ1), the level of moral sensitivity (RQ2), the level of clinical reasoning by subscale and overall (RQ3), and the extent of missed nursing care (RQ4). For inferential analysis, the independent samples t-test (or Mann-Whitney U if assumptions were violated) with Cohen's d was used to compare missed nursing care between High and Low moral sensitivity groups (RQ5) and between High and Low clinical reasoning groups (RQ6). A two-way ANOVA examining main effects and interaction with partial eta-squared (η^2p) was used to compare missed nursing care across the four combined moral sensitivity $\times$ clinical reasoning subgroups (RQ7). Normality and homogeneity of variance were verified before analysis; had these assumptions been violated, a robust factorial alternative (e.g., aligned rank transform ANOVA) would have been applied, since the Kruskal-Wallis test evaluates group differences on a single factor and does not test factorial interaction effects. The competency development matrix (RQ8) was derived from the synthesis of findings from RQs 2–7; no inferential test was applied.

Ethical Considerations

This study observed the ethical principles articulated in the Declaration of Helsinki (WMA, 2013), the Belmont Report (1979), and CIOMS (2016). Written informed consent was secured from all respondents. Participation was voluntary, with no compensation provided, and respondents could withdraw at any time without consequence. Confidentiality was maintained by coding responses numerically, reporting data only in aggregate, and storing consent forms separately from questionnaires. All data were kept in locked storage and password-protected files accessible only to the researchers, in compliance with Republic Act No. 10173 (the Data Privacy Act of 2012). The study posed minimal risk — primarily time burden and potential discomfort from reflecting on care omissions.

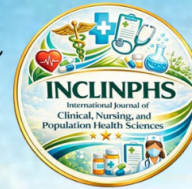
RESULTS and DISCUSSION

This descriptive-comparative, cross-sectional study was conducted among 211 staff nurses in two tertiary hospitals (one government, one private) in Valenzuela City, Metro Manila. Data were collected using the MSQ-R (Lützen et al., 2006), the CRCS (Bae et al., 2023), and MISSCARE Survey Part A (Kalisch & Williams, 2009). Internal consistency with the study sample was acceptable to excellent: MSQ-R $\alpha = .826$, CRCS total $\alpha = .892$ (subscales: Plan Setting = .837, Intervention Strategy Regulation = .868, Self-Instruction = .763), and MISSCARE $\alpha = .912$ — all exceeding the $\alpha \geq .70$ threshold (interpreted per George & Mallery, 2019: $\alpha \geq .90$ = excellent, $\geq .80$ = good, $\geq .70$ = acceptable).

Table 1

Demographic and Professional Profile of the Respondents

Variable / Category	<i>f</i>	%
Age		
22–25	56	26.5
26–30	68	32.3
31–35	42	19.9
36–40	27	12.8
41 and above	18	8.5
Total	211	100.0
Sex		
Male	63	29.9
Female	148	70.1
Total	211	100.0

**Highest Educational Attainment**

BSN	158	74.9
With MA/MS Units	38	18.0
MA/MS Graduate	15	7.1
Total	211	100.0

Years of Clinical Experience

6 months–1 year	32	15.2
1–3 years	62	29.4
4–6 years	48	22.7
7–10 years	40	19.0
More than 10 years	29	13.7
Total	211	100.0

Current Unit/Ward Assignment

Medical-Surgical	72	34.2
Pediatric	28	13.3
Obstetric	25	11.8
ICU	38	18.0
Emergency Department	33	15.6
Others	15	7.1
Total	211	100.0

Employment Status

Regular/Permanent	134	63.5
Contractual/Casual	58	27.5
Job Order	19	9.0
Total	211	100.0

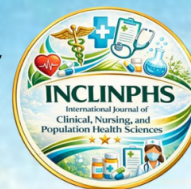
Average Patients per Shift

1–5	28	13.3
6–10	62	29.4
11–15	65	30.8
16–20	38	18.0
More than 20	18	8.5
Total	211	100.0

Note. $N = 211$.

The respondents were predominantly female ($n = 148$, 70.1%) and concentrated in the younger age brackets, with 58.8% aged 30 or below. Three fourths held a BSN as their highest educational attainment (74.9%). Nearly half the sample (44.6%) had three years or fewer of clinical experience, and the largest experience group was 1–3 years (29.4%). Medical-Surgical was the most common unit assignment (34.2%), followed by ICU (18.0%) and the Emergency Department (15.6%). The majority held regular or permanent positions (63.5%), though 36.5% were contractual, casual, or job order employees. Patient loads were concentrated in the 6–15 range (60.2%), and 26.5% of respondents handled 16 or more patients per shift (Table 1).

The sample reflected the demographic composition typical of the Philippine hospital nursing workforce: predominantly female, young, and baccalaureate-prepared (Alibudbud, 2023). The concentration of early-career



nurses and the predominance of Medical-Surgical assignments were consistent with staffing patterns in Metro Manila tertiary hospitals. The proportion of non-permanent employees (36.5%) reflected the employment precarity documented in the Philippine nursing labor market (Alibudbud, 2023; Tamayo et al., 2022). The patient load data — with over a quarter handling 16 or more patients per shift, well above the Department of Health's 1:12 standard — established a structural context directly relevant to the occurrence of missed nursing care examined in RQs 4–7.

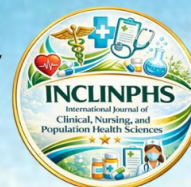
Table 2*Level of Moral Sensitivity Among the Respondents*

Indicator	<i>M</i>	<i>SD</i>	VI	Rank
I find it very difficult to deal with my feelings that are aroused when a patient is suffering. (MS6)	4.52	0.84	High	1
I have a very good ability to feel how I should talk about difficult things with the patient. (MS3)	4.44	0.95	High	2
I always feel a responsibility for the patient receiving good care even if the resources are inadequate. (MS1)	4.42	0.91	High	3
My ability to sense a patient's needs means that I often find myself in situations in which I feel inadequate. (MS8)	4.40	0.86	High	4
My ability to sense the patient's needs is always helpful in my work. (MS2)	4.17	0.97	Moderately High	5
My ability to sense the patient's needs means that I do more than I have the strength for. (MS4)	4.12	0.97	Moderately High	6
When caring for patients, I am always aware of the balance between the potential for doing good and the risk of causing harm to them. (MS7)	4.04	1.11	Moderately High	7
I have a very good ability to sense when a patient is not receiving good care. (MS5)	3.98	1.17	Moderately High	8
It helps me to know what is good or bad for the patient when I can follow rules and regulations. (MS9)	3.93	1.09	Moderately High	9
Moral Sensitivity (Overall)	4.23	0.64	Moderately High	

Note. *N* = 211. Likert scale: 1 = Totally Disagree to 6 = Totally Agree. VI: 1.00–1.83 = Very Low; 1.84–2.67 = Low; 2.68–3.50 = Moderately Low; 3.51–4.33 = Moderately High; 4.34–5.17 = High; 5.18–6.00 = Very High.

The respondents reported a moderately high level of moral sensitivity ($M = 4.23$, $SD = 0.64$). Four of the nine items reached the High threshold (≥ 4.34), led by MS6 — emotional response to patient suffering ($M = 4.52$, $SD = 0.84$). The remaining five items fell within the Moderately High range. The lowest-rated item was MS9 — reliance on rules and regulations ($M = 3.93$, $SD = 1.09$), which also exhibited one of the highest standard deviations, indicating variability in how respondents perceived the role of institutional guidelines in ethical decision-making. No item dropped below the 3.51 threshold (Table 2).

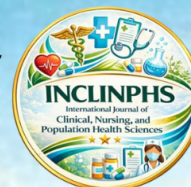
The moderately high composite positioned the respondents within the range reported in a systematic review of 99 studies involving 29,387 nurses, where moderate levels were the global norm with substantial variation across settings and regions (Zhao et al., 2025). The internal composition of the construct was more telling than the composite. The four highest-rated items clustered in the affective domain — emotional engagement with suffering, communication about difficult matters, felt responsibility despite resource constraints, and discomfort with perceived inadequacy — while the lowest-rated item addressed rule-based guidance. Within Rest's (1983) Four-Component Model, this pattern suggested that moral sensitivity among this sample operated predominantly through the perceptual-affective gateway of Component 1 (recognizing moral dimensions) rather than through cognitive-regulatory mechanisms. Kovancı and Atlı Özbaş (2024) documented a parallel pattern among Turkish clinical nurses, where heightened affective attunement coexisted with vulnerability to moral distress when institutional constraints



prevented ethically congruent action — a tension likely amplified in the Philippine context, where nurse-to-patient ratios reaching 1:20 to 1:50 create structural barriers to fulfilling recognized ethical obligations (Alibudbud, 2023; Tamayo et al., 2022).

Table 3*Level of Clinical Reasoning Among the Respondents*

Subscale / Indicator	<i>M</i>	<i>SD</i>	<i>VI</i>	Rank
Plan Setting				
Prioritize problem solving strategies. (CR_PS3)	4.01	0.74	High	1
Distinguish the importance of the data. (CR_PS1)	3.94	0.74	High	2
Relate the knowledge to the information. (CR_PS5)	3.89	0.69	High	3
Analyze the cause of an error during nursing care. (CR_PS7)	3.83	0.79	High	4
Discover important problems based on the data. (CR_PS2)	3.77	0.76	High	5
Comprehensively grasp the relationship between the patient data. (CR_PS4)	3.70	0.80	High	6
Find any problems in the care and correct them immediately. (CR_PS8)	3.66	0.91	High	7
Understand the overall patient situation. (CR_PS6)	3.55	0.91	High	8
<i>Plan Setting (Subscale)</i>	<i>3.79</i>	<i>0.54</i>	<i>High</i>	
Intervention Strategy Regulation				
Evaluate the nursing intervention. (CR_ISR6)	4.03	0.70	High	1
A process of sufficient deliberation for interventions. (CR_ISR1)	4.00	0.70	High	2
Continuously check the missing parts in solving the patient's problem. (CR_ISR2)	3.99	0.73	High	3
Collect additional data to close the gap between the information. (CR_ISR4)	3.96	0.72	High	4.5
Repeatedly reflect the process of solving the patient's problem. (CR_ISR10)	3.96	0.69	High	4.5
Identify a better way to solve the problem even after solving the patient's problem. (CR_ISR11)	3.92	0.74	High	6
Reflect the anything wrong with the plan before intervention. (CR_ISR8)	3.92	0.74	High	7
A different perspective on patient's health problems. (CR_ISR3)	3.89	0.70	High	8
Identify the other method to solve the patient's problem. (CR_ISR7)	3.86	0.76	High	9
Compare the results of the patient's problem solving with the target level. (CR_ISR9)	3.76	0.88	High	10
Provide integrative interventions considering the patient and situation. (CR_ISR5)	3.76	0.82	High	11
<i>Intervention Strategy Regulation (Subscale)</i>	<i>3.91</i>	<i>0.49</i>	<i>High</i>	
Self-Instruction				
Interested in acquiring new information related to the field	3.81	0.78	High	1



of work. (CR_SI1)

Look for answers to questions don't know on my own. (CR_SI2)	3.74	0.79	High	2
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Invest extra time to encounter problems to acquire don't know about the field of work. (CR_SI3)	3.65	0.83	High	3
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Self-Instruction (Subscale)	3.74	0.66	High	
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Clinical Reasoning (Overall)	3.85	0.43	High	
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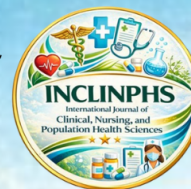
Note. $N = 211$. Likert scale: 1 = Not at All to 5 = Always. VI: 1.00–1.80 = Very Low; 1.81–2.60 = Low; 2.61–3.40 = Moderate; 3.41–4.20 = High; 4.21–5.00 = Very High. Ranks assigned within each subscale; tied ranks reflect identical values at three decimal places.

Clinical reasoning was rated High overall ($M = 3.85$, $SD = 0.43$), and all three subscales fell within the same interpretive range. Intervention Strategy Regulation obtained the highest subscale mean ($M = 3.91$, $SD = 0.49$), followed by Plan Setting ($M = 3.79$, $SD = 0.54$) and Self-Instruction ($M = 3.74$, $SD = 0.66$). The highest-rated item across all subscales was CR_ISR6 — evaluating nursing interventions ($M = 4.03$, $SD = 0.70$), while the lowest was CR_PS6 — understanding the overall patient situation ($M = 3.55$, $SD = 0.91$). All 22 items remained above the 3.41 High threshold (Table 3).

The subscale hierarchy mapped meaningfully onto Tanner's (2006) Clinical Judgment Model. Intervention Strategy Regulation — the highest subscale — corresponds to the *responding* phase (selecting and implementing clinical actions), while Self-Instruction — the lowest — corresponds to *reflecting* (self-directed learning and critical self-review). The respondents' strength in the action-oriented phase and relative modesty in the reflective phase suggested that clinical reasoning among this sample was more execution-focused than reflection-focused, a tendency that may reflect time-pressured clinical environments where immediate action is rewarded over deliberate self-assessment (Bae et al., 2023). Mohammadi et al. (2024) confirmed the three-factor structure of the CRCS among Iranian critical care nurses, supporting its cross-cultural applicability, though direct comparison of subscale levels across samples was not the focus of their validation study. Doyon and Raymond (2025), in a bibliometric analysis of 1,528 studies, observed that clinical reasoning remains actively researched yet its measurement in practicing nurses — as opposed to students in simulation settings — remains underdeveloped, leaving gaps in understanding how the construct operates in real clinical conditions. Tanner (2006) identified reflection as the phase most critical for clinical knowledge development, making the relative softness of Self-Instruction a finding worth monitoring in continuing professional development programs.

Table 4
Extent of Missed Nursing Care Among the Respondents

Indicator	<i>M</i>	<i>SD</i>	VI	Rank
Setting up meals for patients who feed themselves (MNC4)	3.83	0.72	Rarely Missed	1
Ambulation three times per day or as ordered (MNC1)	3.71	0.74	Rarely Missed	2
Turning patient every 2 hours (MNC2)	3.67	0.73	Rarely Missed	3
Assess effectiveness of medications (MNC19)	3.64	0.73	Rarely Missed	4
Medications administered within 30 minutes before or after scheduled time (MNC5)	3.63	0.75	Rarely Missed	5
Bedside glucose monitoring as ordered (MNC21)	3.61	0.82	Rarely Missed	6
PRN medication requests acted on within 15 minutes (MNC18)	3.58	0.70	Rarely Missed	7
Response to call light is initiated within 5 minutes (MNC17)	3.56	0.75	Rarely Missed	8
Feeding patient when the food is still warm (MNC3)	3.54	0.76	Rarely Missed	9.5
Discharge planning and teaching (MNC20)	3.54	0.76	Rarely Missed	9.5
Monitoring intake and output (MNC7)	3.53	0.77	Rarely Missed	11
Vital signs assessed as ordered (MNC6)	3.50	0.80	Rarely Missed	12

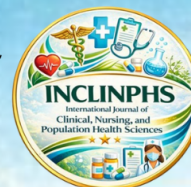


Skin/wound care (MNC23)	3.48	0.84	Rarely Missed	13
Patient is assisted with toileting needs within 5 minutes of request (MNC22)	3.47	0.76	Rarely Missed	14
Attend interdisciplinary care conferences whenever held (MNC24)	3.42	0.79	Rarely Missed	15
IV/central line site care and assessment per hospital policy (MNC16)	3.40	0.71	Occasionally Missed	16
Patient bathing/skin care (MNC11)	3.39	0.78	Occasionally Missed	17
Emotional support to patient and/or family (MNC10)	3.33	0.85	Occasionally Missed	18
Focused reassessments per patient condition (MNC15)	3.24	0.85	Occasionally Missed	19
Hand washing (MNC13)	3.24	0.78	Occasionally Missed	20
Full documentation of all necessary data (MNC8)	3.22	0.81	Occasionally Missed	21.5
Patient assessment performed each shift (MNC14)	3.22	0.88	Occasionally Missed	21.5
Patient teaching about illness, tests, and diagnostic studies (MNC9)	3.20	0.81	Occasionally Missed	23
Mouth care (MNC12)	3.09	0.85	Occasionally Missed	24
Missed Nursing Care (Overall)	3.46	0.45	Rarely Missed	

Note. $N = 211$. Likert scale: 1 = Always Missed to 5 = Never Missed. Lower scores indicate greater extent of missed care. VI: 1.00–1.80 = Always Missed; 1.81–2.60 = Frequently Missed; 2.61–3.40 = Occasionally Missed; 3.41–4.20 = Rarely Missed; 4.21–5.00 = Never Missed. Tied ranks reflect identical values at three decimal places.

The overall extent of missed nursing care fell within the Rarely Missed range ($M = 3.46$, $SD = 0.45$), though the composite score positioned near the lower boundary of this category (threshold = 3.41). Of the 24 care elements, 15 were rated Rarely Missed and nine crossed into the Occasionally Missed range (≤ 3.40). The least frequently missed activities were meal setup ($M = 3.83$), ambulation ($M = 3.71$), and patient turning ($M = 3.67$) — task-oriented, time-bound activities. The most frequently missed were mouth care ($M = 3.09$), patient teaching ($M = 3.20$), and per-shift assessment ($M = 3.22$, tied with full documentation) — activities requiring sustained nurse presence, communication, or extended attention. The nine Occasionally Missed items clustered in the domains of hygiene, documentation, assessment, infection control, education, and psychosocial support (Table 4).

The Rarely Missed composite, while above the threshold, aligned with studies where missed care was present but did not reach pervasive levels (Gong et al., 2025; Taskiran Eskici et al., 2025). The proximity to the Occasionally Missed boundary ($M = 3.46$ against a threshold of 3.41) warrants attention rather than reassurance. The pattern of which activities were preserved and which were omitted was consistent with international evidence: a systematic review of 28 studies across 14 countries identified ambulation, mouth care, and patient education among the most frequently omitted activities globally (Gong et al., 2025). Among Filipino frontline nurses during the pandemic, Labrague et al. (2022) reported that patient surveillance, comfort measures, and skin care were the most frequently missed, with staffing and patient safety culture as the strongest predictors. The clustering of Occasionally Missed items in this study — mouth care, patient teaching, documentation, per-shift assessment, hand washing, emotional support — reflected activities demanding sustained engagement rather than procedural execution. This pattern aligns with Imam et al.'s (2023) observation that in low- and middle-income settings, resource scarcity and high patient-to-nurse ratios amplify the frequency and scope of care omissions beyond what is typically reported in high-income contexts. The present study's data suggested that this amplification was not uniform: activities requiring relational and cognitive effort were more vulnerable than time-bound procedural tasks.

**Table 5***Difference in Missed Nursing Care by Level of Moral Sensitivity*

Group	<i>n</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>df</i>	<i>p</i>	Decision	<i>d</i>	Magnitude	95% CI
High MS	120	3.57	0.44	4.21	209	< .001	Reject Ho ₁	0.59	Medium	[0.13, 0.37]
Low MS	91	3.32	0.42							

Note. *N* = 211. Groups formed by median split of MS_Total (*Mdn* = 4.222). DV = Missed Nursing Care overall mean (MNC_Total). Higher MNC scores indicate less missed care. 95% CI refers to the mean difference. *d* = Cohen's *d*.

p* < .05. *p* < .01. ****p* < .001.

Shapiro-Wilk and Levene's tests confirmed normality and homogeneity of variance for both groups (formed by median split of MS_Total). The independent samples *t*-test revealed a statistically significant difference in missed nursing care between the High MS group (*M* = 3.57, *SD* = 0.44) and the Low MS group (*M* = 3.32, *SD* = 0.42), *t*(209) = 4.21, *p* < .001, *d* = 0.59 (medium), 95% CI [0.13, 0.37]. Respondents with high moral sensitivity reported less missed care. The null hypothesis was rejected (Table 5).

The medium effect size (*d* = 0.59) indicated a substantive, not trivial, group difference. This finding corroborated the growing evidence linking moral sensitivity to care completion: Nobahar et al. (2023) reported a negative association between moral sensitivity and missed care among Iranian ICU nurses, Jia et al. (2025) replicated this among Chinese ICU nurses, and Xu et al. (2025) demonstrated a significant inverse relationship among new nurses with fewer than two years of experience. Taskiran Eskici et al. (2025) advanced this line of inquiry by demonstrating that moral sensitivity partially mediated the effect of professional values on missed nursing care (indirect effect β = -0.172), positioning moral sensitivity not merely as a correlate but as a mechanism through which broader professional orientations translate into care delivery behaviors.

Not all evidence converges. Ahansaz et al. (2024) found no significant bivariate correlation between moral sensitivity and missed care among Iranian medical-surgical nurses, though regression analysis controlling for demographic and work-condition variables revealed moral sensitivity as a significant predictor — suggesting the relationship may be obscured when structural confounders are uncontrolled.

Theoretically, the finding aligned with Rest's (1983) model: moral sensitivity represents the first component — the recognition that a care situation carries ethical weight. Without this recognition, the downstream processes of moral judgment, moral motivation, and moral character cannot be activated. Nurses who scored higher on moral sensitivity may have been more likely to recognize the ethical demand embedded in each care activity, making omission a more salient ethical violation and thus less likely. The practical implication pointed to moral sensitivity development — through ethical case reflection and structured moral deliberation — as a viable strategy for reducing care omissions alongside structural interventions such as staffing adjustments.

Table 6*Difference in Missed Nursing Care by Level of Clinical Reasoning*

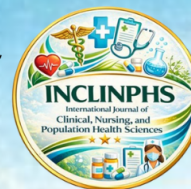
Group	<i>n</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>df</i>	<i>p</i>	Decision	<i>d</i>	Magnitude	95% CI
High CR	111	3.60	0.43	4.94	209	< .001	Reject Ho ₂	0.68	Medium	[0.17, 0.41]
Low CR	100	3.31	0.42							

Note. *N* = 211. Groups formed by median split of CR_Total (*Mdn* = 3.864). DV = Missed Nursing Care overall mean (MNC_Total). Higher MNC scores indicate less missed care. 95% CI refers to the mean difference. *d* = Cohen's *d*.

p* < .05. *p* < .01. ****p* < .001.

Normality and homogeneity assumptions were satisfied. The *t*-test revealed a statistically significant difference between the High CR group (*M* = 3.60, *SD* = 0.43) and the Low CR group (*M* = 3.31, *SD* = 0.42), *t*(209) = 4.94, *p* < .001, *d* = 0.68 (medium), 95% CI [0.17, 0.41]. Respondents with high clinical reasoning reported less missed care. The null hypothesis was rejected (Table 6).

The medium effect size (*d* = 0.68) — the largest bivariate effect in this study — represented, to our knowledge, the first empirical evidence directly linking clinical reasoning competency to missed nursing care. No published study has previously examined clinical reasoning as a comparative variable in a missed care design (Jessee, 2021; Doyon & Raymond, 2025). Jessee (2021) established that deficits in clinical judgment were implicated



in failure-to-rescue events and missed or delayed care, but this connection had not been tested using a validated clinical reasoning instrument against a validated missed care measure in a comparative design.

Within Tanner's (2006) framework, the finding was conceptually coherent. Nurses with stronger clinical reasoning — greater capacity to notice patient cues, interpret data accurately, select appropriate interventions, and reflect on outcomes — may be better positioned to identify which care activities are clinically necessary and to prioritize them accordingly, which the findings suggest is associated with a lower likelihood of omission. The slightly larger effect for clinical reasoning ($d = 0.68$) compared to moral sensitivity ($d = 0.59$) suggested that cognitive clinical prioritization may differentiate missed care to a somewhat greater degree than ethical attunement alone, though both variables independently differentiated care completion. The practical implication pointed to clinical reasoning development — through simulation-based training, structured clinical debriefing, and case-based learning — as a complementary strategy for reducing missed care.

Table 7*Two-Way Analysis of Variance for Missed Nursing Care by Moral Sensitivity and Clinical Reasoning Levels*

Source	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>	η^2	Magnitude	Decision
Moral Sensitivity (main effect)	1.80	1	1.80	10.30	.002	.047	Small	Reject
Clinical Reasoning (main effect)	2.95	1	2.95	16.83	< .001	.075	Medium	Reject
MS $\times$ CR (interaction)	0.02	1	0.02	0.14	.712	.001	Negligible	Fail to reject
Residuals	36.24	207	0.18					

Note. $N = 211$. DV = Missed Nursing Care overall mean (MNC_Total). Type III sums of squares. Groups formed by median split: MS_Total (Mdn = 4.222) and CR_Total (Mdn = 3.864). Cell descriptives: High MS – High CR ($n = 76$, $M = 3.65$, $SD = 0.43$); High MS – Low CR ($n = 44$, $M = 3.43$, $SD = 0.44$); Low MS – High CR ($n = 35$, $M = 3.48$, $SD = 0.43$); Low MS – Low CR ($n = 56$, $M = 3.21$, $SD = 0.38$). η^2 = partial eta-squared. Magnitude thresholds: Small = .01; Medium = .06; Large = .14.

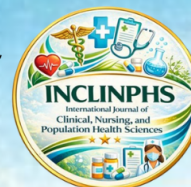
* $p < .05$. ** $p < .01$. *** $p < .001$.

A two-way ANOVA (Type III sums of squares) examined missed nursing care across four subgroups formed by the combination of moral sensitivity and clinical reasoning levels. Assumptions of normality and homogeneity of variance were met across all four cells.

The interaction was not statistically significant, $F(1, 207) = 0.14$, $p = .712$, $\eta^2 = .001$ (negligible), indicating that the two variables operated independently. Both main effects were significant: clinical reasoning, $F(1, 207) = 16.83$, $p < .001$, $\eta^2 = .075$ (medium); and moral sensitivity, $F(1, 207) = 10.30$, $p = .002$, $\eta^2 = .047$ (small). The High MS – High CR subgroup reported the least missed care ($M = 3.65$, $SD = 0.43$), while the Low MS – Low CR subgroup reported the most ($M = 3.21$, $SD = 0.38$) — a mean difference of 0.44, spanning from Rarely Missed to Occasionally Missed. The null hypothesis was rejected for both main effects but not for the interaction (Table 7).

The non-significant interaction indicated that moral sensitivity and clinical reasoning did not combine synergistically to reduce missed care; their contributions were additive. Both main effects were significant within the ANOVA model — clinical reasoning with a medium effect ($\eta^2 = .075$), moral sensitivity with a small effect ($\eta^2 = .047$) — converging with the bivariate findings from RQ5 and RQ6. The 0.44-point gap between the best-performing subgroup (High MS – High CR, $M = 3.65$, Rarely Missed) and the worst-performing subgroup (Low MS – Low CR, $M = 3.21$, Occasionally Missed) crossed a meaningful interpretive boundary.

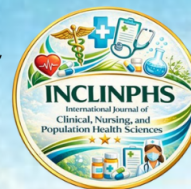
The additive pattern carried both theoretical and practical significance. Rest's (1983) ethical pathway and Tanner's (2006) cognitive pathway operated through distinct mechanisms — one perceptual-affective, the other analytical-evaluative — and the absence of interaction confirmed that strengthening one did not compensate for deficits in the other. Rest's model explained *why* a nurse might miss care: a failure of moral sensitivity meant the ethical demand of the care situation was not recognized, and the motivation to act on the patient's behalf was not activated. Tanner's model explained *how* a nurse might miss care: a breakdown at any phase of clinical judgment meant that a care need was not noticed, not correctly interpreted, not acted upon, or not reflected upon for future prevention. Missed nursing care, as conceptualized by Kalisch and Williams (2009), represented the observable outcome when either or both of these processes failed.



Interventions should therefore target both capacities in parallel: ethical case reflection and moral deliberation to strengthen Rest's Component 1, and simulation-based training, structured debriefing, and case-based learning to develop Tanner's responding and reflecting phases. The independence of the two pathways argued against a single integrated intervention and for complementary, domain-specific development programs — a recommendation that directly informed the competency development matrix proposed in RQ8.

Table 8*Proposed Competency Development Matrix for Reducing Missed Nursing Care*

Pathway	Gap Identified (Finding)	Target Competency	Proposed Intervention	Target Audience	Expected Outcome
<i>Ethical (Rest)</i>	Moral sensitivity is affectively anchored; cognitive-regulatory dimension (rule-based guidance) rated lowest with high variability (RQ2)	Strengthen the cognitive-regulatory component of moral sensitivity alongside the existing affective base	Structured moral deliberation rounds using real-unit ethical dilemmas; guided reflection on institutional rules as ethical tools, not constraints	Staff nurses, unit charge nurses	Broader moral sensitivity profile — ethical recognition grounded in both affect and institutional reasoning
<i>Ethical (Rest)</i>	Nurses with low moral sensitivity reported significantly more missed care, $d = 0.59$ (RQ5)	Elevate moral sensitivity among low-MS nurses to reduce care omissions	Monthly ethical case conferences with facilitated discussion; integration of moral sensitivity self-assessment into annual competency evaluation	Staff nurses, nursing education departments	Reduction in missed care among nurses currently in the low-MS group
<i>Cognitive (Tanner)</i>	Self-Instruction (reflecting) was the lowest clinical reasoning subscale (RQ3)	Strengthen the <i>reflecting</i> phase of Tanner's Clinical Judgment Model	Post-shift structured debriefing using reflective prompts; case-based learning modules with self-directed inquiry components; journaling protocols for complex cases	Staff nurses, clinical educators	Enhanced reflective capacity leading to stronger self-directed clinical learning
<i>Cognitive (Tanner)</i>	Nurses with low clinical reasoning reported significantly more missed care, $d = 0.68$ (RQ6)	Develop clinical reasoning competency among low-CR nurses, particularly in noticing and interpreting (Plan Setting, the second-lowest subscale)	High-fidelity simulation with embedded clinical cues requiring prioritization; structured clinical reasoning exercises using the CRCS framework; preceptor-guided bedside reasoning rounds	Staff nurses, simulation centers, nurse preceptors	Reduction in missed care through improved clinical prioritization
<i>Combined</i>	Additive effect — both pathways independently reduce missed care; Low MS – Low CR subgroup reported the most missed care, $M = 3.21$, Occasionally	Dual-pathway competency development targeting nurses in the Low MS – Low CR profile	Tiered program: (a) identify nurses falling in the Low MS – Low CR quadrant through validated screening using MSQ-R and CRCS; (b) assign to concurrent moral sensitivity and clinical reasoning	Nursing service offices, hospital training departments	Shift of Low MS – Low CR nurses toward higher care completion, narrowing the 0.44-point gap between best- and worst-



	Missed (RQ7)		development tracks; (c) reassess at 6 and 12 months		performing subgroups
<i>Structural Support</i>	Overall missed care sits 0.05 above the Occasionally Missed threshold; nine care activities are Occasionally Missed, concentrated in sustained-attention domains (RQ4)	Create organizational conditions that protect sustained-attention care activities from omission	Targeted care audits for the nine Occasionally Missed activities (mouth care, patient teaching, documentation, per-shift assessment, hand washing, emotional support, bathing, focused reassessment, IV site care); workload redistribution or task-sharing protocols during peak census; dedicated time blocks for documentation and patient education	Nurse managers, hospital administration, quality improvement units	Reduction in the frequency of omission of the nine most vulnerable care activities

Note. The matrix is grounded in the dual theoretical framework: Rest's (1983) Four-Component Model (ethical pathway) and Tanner's (2006) Clinical Judgment Model (cognitive pathway).

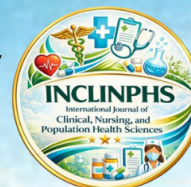
The matrix operationalized the study's central finding: moral sensitivity and clinical reasoning function as independent, additive pathways to care completion, each requiring domain-specific development. The ethical pathway targets Rest's (1983) Component 1 — expanding moral sensitivity beyond its current affective base to include cognitive-regulatory awareness — while the cognitive pathway targets Tanner's (2006) reflecting phase, the dimension where this sample was most modest. The combined row addresses the most vulnerable subgroup (Low MS – Low CR), whose mean missed care score crossed into the Occasionally Missed range, by proposing validated screening followed by concurrent enrollment in both development tracks. The structural row acknowledges that nurse-level interventions operate within organizational constraints: without adequate staffing and workload management, competency development alone cannot sustain care completion at the levels required for patient safety.

Conclusions

The respondents demonstrated moderately high moral sensitivity that was affectively anchored — driven more by emotional attunement to patient suffering than by rule-based ethical guidance — and high clinical reasoning that was stronger in executing and evaluating interventions than in self-directed reflective learning. Missed nursing care, while classified as Rarely Missed overall, sat only 0.05 above the Occasionally Missed threshold, with omissions concentrated in activities requiring sustained nurse presence, communication, and cognitive effort rather than procedural tasks. Both moral sensitivity ($d = 0.59$) and clinical reasoning ($d = 0.68$) independently and significantly differentiated the extent of missed care, with clinical reasoning producing the larger bivariate effect. When examined simultaneously, the two variables operated additively rather than synergistically: the High MS – High CR subgroup reported the least missed care (Rarely Missed) and the Low MS – Low CR subgroup reported the most (Occasionally Missed), but this advantage reflected the sum of two independent effects — not an interaction. Rest's ethical pathway and Tanner's cognitive pathway each accounted for distinct, non-overlapping portions of variance in care completion, confirming that strengthening one capacity does not compensate for deficits in the other. Reducing missed nursing care may also contribute to safer healthcare delivery and improved health outcomes at the system and population levels.

Recommendations

Hospital nursing departments may implement parallel competency development programs targeting moral sensitivity and clinical reasoning as complementary — not integrated — strategies for reducing missed care, given the independent operation of both pathways. Moral sensitivity may be developed through structured ethical case reflection and moral deliberation rounds targeting Rest's Component 1, while clinical reasoning development may emphasize reflection-focused approaches — structured debriefing, case-based learning, and simulation with post-action review — to address the relative softness of the Self-Instruction dimension identified in this sample. Nurse



managers may prioritize monitoring of the nine Occasionally Missed care activities, particularly mouth care, patient teaching, documentation, and per-shift assessment, through targeted audit or workload redistribution. Staffing policies may address the structural conditions associated with care omissions, as nurse-level capacities alone cannot indefinitely compensate for patient-to-nurse ratios exceeding recommended standards. Nursing education programs may integrate moral sensitivity and clinical reasoning as explicitly taught and assessed competencies grounded in Rest's (1983) and Tanner's (2006) frameworks.

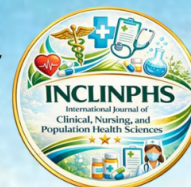
Future research should employ longitudinal or quasi-experimental designs to test whether interventions targeting both capacities produce measurable reductions in missed care over time, establishing the causal direction this cross-sectional study could not confirm. Replication with larger, randomly selected, multi-site samples across Philippine regions would strengthen generalizability. Studies incorporating structural predictors — staffing ratios, workload, nurse practice environment — alongside moral sensitivity and clinical reasoning in multivariate models would clarify the relative contribution of nurse-level attributes versus organizational factors. Qualitative follow-up could explore how nurses with differing moral sensitivity and clinical reasoning profiles describe their decision-making when care activities compete for limited time, providing explanatory depth to the statistical patterns observed here.

Limitations

This study employed a cross-sectional design, precluding causal inference about the direction of relationships among moral sensitivity, clinical reasoning, and missed nursing care. Total population sampling within two hospitals in Valenzuela City limits generalizability to other regions, hospital types, and healthcare systems; findings apply to this sample in this context. All three instruments relied on self-report, introducing the possibility of social desirability bias — particularly for missed nursing care, where respondents may underreport omissions. The median-split approach for forming High and Low groups, while appropriate for the comparative design, dichotomized continuous variables and may obscure nuances at group boundaries. The study did not include structural and organizational variables (staffing ratios, unit-level workload, nurse practice environment) as covariates, which may confound the observed relationships between nurse-level attributes and missed care.

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