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Moral caring competency and moral distress among Ghanaian nurses in adult care settings: A descriptive-correlational study

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Abstract

Background: Nurses in adult care settings frequently encounter moral distress due to the daily ethical obligations they must fulfill. In contrast to other healthcare professionals, nurses often grapple with a heightened frequency of moral dilemmas, resulting in increased moral distress.

Objective: This study aimed to explore the levels and relationship between moral caring competency and moral distress among Ghanaian nurses in adult care settings.

Methods: This quantitative study utilized a descriptive-correlational design. A multistage sampling was used to select three public hospitals. Simple random sampling was used to recruit 231 nurses from the three public hospitals. Data were collected from June to July 2023 using validated questionnaires. The study utilized frequency and percentages, mean and standard deviation, and Spearman's Correlation.

Results: The nurses had a low level of moral caring competency (M = 2.18, SD = 0.340). The composite moral distress score was 227.31, indicating a high level of moral distress among the nurses. Furthermore, there was a moderate, negative significant relationship between moral caring competency and moral distress (r_s = -.474, N = 231, p <0.001).

Conclusions: Nurses in public hospitals had limited personal cognitive, affective, and psychomotor abilities to address patient moral issues. The nurses also experience significant moral distress when delivering patient care. Furthermore, to decrease the level of moral distress, moral caring competency should be strengthened among nurses. Therefore, it is recommended that nurse administrators provide adequate organizational support and implement continuous moral training to improve nurses' moral caring competency and mitigate their moral distress. Healthcare policymakers are encouraged to develop or refine policies to navigate moral dilemmas and reduce moral distress among nurses. Future studies employing qualitative designs can explore the influence of culture on moral caring competency within the Ghanaian setting.

Keywords

moral caring competency; moral distress; moral dilemmas; Ghana; nurses; hospitals; patient care; descriptive-correlational study

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Background

Moral practice is the foundation for nurses, whereby nurses possess an ethico-moral obligation to provide safe and quality patient care (Momennasab et al., 2021). However, in their daily efforts to offer quality care, nurses encounter moral conflicts as frontline caregivers at the bedside (Hoskins et al., 2018). Compared to other healthcare workers, according to Giannetta et al. (2021), 42% of nurses internationally confront a greater number of moral dilemmas in the clinical context (Prompahakul et al., 2021; Quek et al., 2022). In an attempt to mitigate this phenomenon, the International Council of Nurses (ICN) Code for Ethics and the American Nurses Association (ANA) developed a model for a professional code of ethics for nurses (Ramathuba & Ndou, 2020). The principles of autonomy, beneficence, justice, and nonmaleficence were critical ethical and moral principles integrated into nursing. Despite the efforts of global health organizations, nurses are confronted with ethical challenges that may risk the quality standard of patient care (Giorgini et al., 2015; Rosa et al., 2022).

The disparity between the level of moral distress among nurses due to moral issues is evident between higher and lower-income countries (Salari et al., 2022; Sirilla et al., 2017). The research conducted by Pathman et al. (2022) and Ulrich et al. (2014) demonstrated that American nurses (44%) possess a high level of moral readiness and confidence, which resulted in a low level of moral distress. On the other hand, lower-income countries in sub-Saharan Africa, such as Ghana (Tia et al., 2022), Ethiopia (Miljeteig et al., 2019), Tanzania (Aboud et al., 2014), and Nigeria (Ulrich et al., 2010), nurses experienced moral distress in moderate to high levels.

In Ghana, 69% of nurses experience morally distressing situations with a greater incidence and severity than in other

Asian countries (Hoskins et al., 2018; Joseph et al., 2022). This occurrence can be ascribed to the moral challenges that Ghanaian nurses face related to the cultural and patient factors involving donations of organs, transplants, and palliative or hospice care decisions (Haile, 2022; Hoglund et al., 2010), and organizational factors, including inadequate resources and insufficient educational training on nursing ethics (Bah & Sey-Sawo, 2018; Prompahakul et al., 2021). Differing cultural backgrounds can impact moral practices and standards in healthcare (Wright et al., 1997). Therefore, to deliver moral and individualized care, nurses are encouraged to incorporate the patient and family's cultural beliefs, values, and needs into their nursing practice (Tia et al., 2022).

The Nursing and Midwifery Council (NMC), a statutory organization in Ghana that oversees the midwifery and nursing professions, has an ethics code that also governs and guides nurses' morals in healthcare (Nyante et al., 2020). The objective of the code of ethics is to make Ghanaian nurses aware of the highest standard needed to fulfill their professional obligation regarding the key ethical principles. However, Tia et al. (2022) noted a surge of growing public concern regarding the moral practices of Ghanaian nurses due to increased moral distress. This often manifests in accusations and complaints regarding unethical behavior and a growing trend of lawsuits against Ghanaian nurse professionals (Boafo, 2016; Moodley et al., 2020).

When repeatedly confronted with moral dilemmas in the clinical setting, nurses become exceedingly vulnerable to moral distress (Quek et al., 2022; Zagenhagen & Van Rensburg, 2018). In this study, moral distress was operationally defined as a psychological discomfort that occurs when a nurse knows the correct course of action in morally challenging situations but is unable to act upon it. Decreased work satisfaction, burnout, and high turnover of nurse employees have all also been attributed to unresolved moral dilemmas (Park et al., 2014).

Studies in different settings have shown varied levels of nurses' moral distress. Nepalese nurses (82.5%) working in teaching hospitals encountered mild degrees of moral distress (Ale et al., 2022). Likewise, the findings of Talebian et al. (2022) revealed that 95.8% of intensive care nurses experienced minimal moral distress. The low levels of nurses' moral distress can be attributed to their increased use of resilience and growing tolerance for moral distress as they gain experience (Clark et al., 2021). On the contrary, morally distressing situations among nurses in public hospitals in Thailand (Wright et al., 1997) and Ethiopia (Berhie et al., 2020) were found to be high, ranging from 70% to 83.7%, respectively. Addo et al. (2020) study posited that the moral distress of Ghanaian nurses often had detrimental effects on their clinical work output and wellness.

Moral caring competency enables nurses to determine the optimal course of moral action for patients and is, therefore, a crucial component of high-quality care (Andersson et al., 2022; Koskenvuori et al., 2019). In this study, moral caring competency is operationally defined as a nurse's ability to recognize, judge, prioritize, follow intentions, and make decisions to address moral issues in patient care. A nurse's moral caring competency is composed of five essential subdimensions: moral sensitivity, judgment, motivation, character, and decision-making (Asahara et al., 2013).

Diverse clinical settings and countries have yielded varying levels regarding the moral caring competency of nurses. Studies conducted among nurses in teaching hospitals in Ghana (Asare et al., 2022), Malaysia (Elewa, 2020), and Nigeria (Oelhafen & Cignacco, 2020) suggested that 78%, 86.74%, and 82.6% of nurses, respectively, possessed high knowledge and positive attitude towards nursing moral-ethics, due to seminars and workshops centered on moral decision-making. In contrast, research conducted in public and remote medical facilities in Ghana (Donkor & Andrews, 2011) and Barbados (Hariharan et al., 2006) discovered that the nurses had poor moral knowledge and lacked the ability to evaluate moral dilemmas. The dearth of moral support and educational opportunities regarding moral issues within the public health sector was identified as the underlying cause.

The Corley Moral Distress Theory (Corley et al., 2001) served as a theoretical framework to examine the correlation between the primary variables in this research study's context – moral caring competency and moral distress. In this theory, one of the major attributes described as a moral concept is possessing moral caring competency. Nurses' moral caring competency is characterized by five subdimensions: moral sensitivity, judgment, motivation, character, and decision-making, which accords with the theory's composition of moral competency among nurses (Corley et al., 2001). A nurse with high moral sensitivity can identify moral issues and determine the moral course of action when combined with sound moral judgment. Moral motivation and character provide the necessary drive and moral foundation for the nurse to act on their moral judgments, ultimately leading to effective moral decision-making and increased moral caring competency. The model suggests that the nurse's perceived moral caring competency will directly influence how they manage morally challenging situations in the clinical setting (Corley et al., 2001). Moral distress results from the nurse's inability to act morally appropriately, which negatively impacts the patient, the nurse, and the organization.

Reviewing past literature has provided conflicting results regarding the level of moral caring competency (Asare et al., 2022; Donkor & Andrews, 2011; Hariharan et al., 2006; Oelhafen & Cignacco, 2020) and moral distress (Ale et al., 2022; Berhie et al., 2020; Talebian et al., 2022) experienced by nurses. In addition, there is a paucity of literature that focuses on the association between moral caring competency and moral distress. Hence, the lack of empirical evidence on moral caring competency and moral distress within public hospitals limits the development of organizational strategies, policies, support systems, resources, and training.

Therefore, the study aimed to explore the influence of moral caring competency on moral distress among Ghana nurses. Specifically, this study's research questions included the following: 1) What is the level of moral caring competency among Ghanaian nurses in adult care settings? 2) What is the level of moral distress among Ghanaian nurses in adult care settings? 3) Is there a significant relationship between moral caring competency and moral distress?

Methods

Study Design

This quantitative study utilized a descriptive-correlational design. The study employed a descriptive design to assess nurses' levels of moral caring competency and moral distress. A correlational design was used to determine the relationship between moral caring competency and moral distress.

Samples/Participants

The study was conducted among nurses within public hospitals in Ghana. A multistage random sampling technique was used to select three public hospitals from three regions: Greater Accra Region, Bono Region, and Northern Region. All clusters of districts, public hospitals, and nurses at each stage were selected using a simple random sampling technique via an electronic random number generator. The OpenEpi Version 3.01 software determined sample sizes for each hospital population using a 95% confidence level and a 5% confidence interval (margin of error).

The respondent's inclusion criteria were 1) being a full-time nurse of the selected hospitals, 2) having one or more years of working experience, and 3) being involved in direct patient care in adult care settings. The respondent's exclusion criteria were 1) nurse administrators and supervisors, 2) float nurses in the present clinical unit, and 3) working in non-adult care settings. The proposed sample size was 243; however, the study had a total of 231 respondents, indicating a 95% response rate. A total of twelve questionnaires, representing 5% of the floated questionnaires, were omitted from the study due to their incompleteness (8), non-returns (3), and withdrawal (1).

Instruments

The first section of the instrument was based on the demographic profile of the respondents, namely sex, age, years of clinical experience, and clinical unit of assignment. This study adopted the Moral Competence Scale (MCS), a standardized tool developed by Asahara et al. (2013). MCS had an internal reliability and validity with a Cronbach alpha 0.93 (Asahara et al., 2013). In this study, the tool yielded a Cronbach alpha of 0.891. The Moral Competence Scale is a self-assessment tool that measures five subdimensions: moral sensitivity, judgment, motivation, character, and decision-making. All respondents had to rate each of the 45 items using a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). MCS verbal interpretation ranged from very low to very high moral caring competency (Asahara et al., 2013). Furthermore, the scoring methodology in this study was determined using mean ranges, as guided by the tool developers (Asahara et al., 2013) (see **Table 1**). This scoring system is supported by the study of Maluwa et al. (2021), which employed the same moral competency tool in Africa utilizing mean ranges.

This study also adopted the Moral Distress Scale-Revised (MDS-R) Questionnaire, a standardized tool developed by Corley et al. (2001) and further revised by Hamric et al. (2012). MDS-R had an internal reliability and validity with a Cronbach alpha of 0.89 (Hamric et al., 2012). In this study, the tool yielded a Cronbach alpha of 0.830. The 21 items on the Moral Distress Scale-Revised represented morally challenging situations that nurses may consider morally distressing. The nurse respondents were required to score each item based on how repeatedly the situation occurred (frequency) and how alarming or distressing the situation was when it occurred (intensity) in the clinical setting (Hamric et al., 2012). Each of the items was rated using a 5-point Likert scale. MDS-R verbal interpretation ranged from low to high moral distress.

Table 1 Scoring system for moral caring competency

Scale Value	Mean	Description
5	4.21-5.00	Very High
4	3.41-4.20	High
3	2.61-3.40	Moderate
2	1.81-2.60	Low
1	1.00-1.80	Very Low

Furthermore, Hamric et al. (2012), the tool developer, provided a scoring system for the MDS-R instrument. The frequency and intensity scores for each item can be examined separately and computed in a composite score. This composite score for overall moral distress was calculated in a two-part procedure. First, the frequency and intensity mean scores were multiplied for each of the 21 items. This created a new variable for each item, the frequency × intensity (fxi) score, which ranges from 0 to 16 (Hamric et al., 2012). Items rarely experienced or minimally distressing had low fxi scores, and items experienced frequently and as most distressing had higher fxi scores. Next, the composite score was obtained by summing each item's fxi score. The resulting composite score based on 21 items ranges from 0–336 (Hamric et al., 2012) (see **Table 2**).

Permission to utilize the Moral Competence Scale (MCS) and Moral Distress Scale-Revised (MDS-R) questionnaires in this study was granted by the instrument developers. The official language of Ghana is English; thus, the researchers did not translate the questionnaires into any local dialect in Ghana. All Ghanaian nurses speak, communicate, and understand the English language.

Table 2 Scoring system for moral distress

Category	Composite Score	Description
3	169-336	High
2	85-168	Moderate
1	0-84	Low

Data Collection

Data collection was conducted among nurses within public hospitals in Ghana. Data collection occurred from June to July 2023. The researchers employed three research assistants in Ghana with quantitative research experience. The research assistants underwent training sessions conducted by the researchers, which ran two hours each for three days. The trained research assistants were under the supervision of the researchers throughout the data collection procedures. The researchers oversaw the entire data-gathering process to ensure adherence to the study's objectives.

The researchers and the research assistants collected data after approval and endorsement by the hospitals' nurse administrators and head nurses. Upon receiving informed consent, the respondents filled out the research questionnaires. The respondents were given 48 hours to

complete the questionnaires during their non-duty hours to avoid disruption of daily nursing routines. The research assistants encoded the data under the supervision and guidance of the researchers.

Data Analysis

In this study, Statistical Package of Social Services (SPSS) version 22 software was utilized for data analysis employing descriptive and inferential statistics. The nurse respondents' demographic profile was determined using frequency and percentage distribution. Descriptive statistics: mean and standard deviation were utilized to determine the levels of moral caring competency and moral distress among nurses. The normality of the data was assessed using the Kolmogorov-Smirnov test. Given the non-normal distribution of the data, the Spearman correlation coefficient was employed for analysis. Hence, the relationship between moral caring competency and moral distress was determined using Spearman's Correlation Coefficient.

Ethical Consideration

The researcher obtained three ethical approvals from the Research Ethics Committees of a university and two health organizations, namely 1) Saint Louis University Research Ethics Committee (SLU-REC 2023-016), 2) Christian Health Association of Ghana Institutional Review Board (CHAG-IRB 02052023), and 3) Ghana Adventist Health Services Ethics Research Committee (GAHS-ERC 00223).

The respondents were informed about the purpose and procedures of the study, and informed consent was sought. Participation was voluntary, and no compensation was given to the study participants. The respondents had the right and power to refuse or withdraw from the study without facing any penalty. Anonymity and privacy were adhered to throughout the study, in which the respondents' identities and any identifiable information were not included in the study report. All other ethical research principles were observed throughout the study.

Results

Characteristics of Participants

The study participants' demographic characteristics were described in terms of their sex, age, years of clinical experience, and clinical unit of assignment. Based on the 231 respondents, 154 (66.7%) were females and 77 (33.3%) were males. Most participants, 79 (34.2%), were aged 30-34. Regarding their years of clinical experience, the majority of the participants, 98 (42.4%), had 1-3 years of clinical experience. Regarding their clinical unit of assignment, most of the participants, 76 (32.9%), were assigned to the medical unit. **Table 3** further describes the characteristics of the participants.

Level of Moral Caring Competency

Table 4 presents the level of moral caring competency among nurses. The findings of the study revealed that the overall mean score was 2.18 (SD=0.340), indicating low levels of moral caring competency among the nurse respondents within public hospitals. The five dimensions of moral caring competency demonstrated varying results in this study, ranging from very low to moderate levels.

Table 3 Demographic characteristics of participants (*N* = 231)

Demographics	f	%
Sex		
Female	154	66.7
Male	77	33.3
Age		
20-24 Years	51	22.1
25-29 Years	76	32.9
30-34 Years	79	34.2
35 Years and Above	25	10.8
Years of Clinical Experience		
1-3 Years	98	42.4
4-6 Years	74	32.0
7-9 Years	36	15.6
10 Years and Above	23	10.0
Clinical Unit of Assignment		
Emergency Care Unit	43	18.6
Medical Unit	76	32.9
Surgical Unit	68	29.4
Operating Theatre Unit	29	12.6
Intensive Care Unit	15	6.5

Table 4 Level of moral caring competency among nurses (*N* = 231)

Domain	Mean	SD	Interpretation
Moral Sensitivity	2.29	0.520	Low
Moral Judgment	1.76	0.432	Very Low
Moral Motivation	2.63	0.845	Moderate
Moral Character	2.72	0.752	Moderate
Moral Decision-Making	2.01	0.415	Low
Overall Mean	**2.18**	**0.340**	**Low**

Legend: 4.20-5.00 (Very High Moral Caring Competency), 3.40-4.19 (High Moral Caring Competency), 2.60-3.39 (Moderate Moral Caring Competency), 1.80-2.59 (Low Moral Caring Competency), 1.00-1.79 (Very Low Moral Caring Competency)

Level of Moral Distress

In **Table 5**, the findings of the study show that the composite moral distress score is 227.31, indicating high levels of moral distress among the Ghanaian nurse respondents. The highest ranked item *was "I follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient* (fxi score= 12.54), and the lowest ranked item was *"I ignore situations in which patients have not been given adequate information to insure informed consent"* (fxi score = 9.81).

Relationship between Moral Caring Competency and Moral Distress

Table 6 presents the relationship between moral caring competency and moral distress among nurses. The study showed a moderate, negative significant relationship between moral caring competency and moral distress (r_s = -0.474, *N* = 231, *p* <0.001). This may suggest that moral distress decreases when nurses' moral caring competency increases, which is an inverse correlation. The study's results reject the null hypothesis that there is no significant relationship between moral caring competency and moral distress.

Table 5 Level of moral distress among nurses (*N* = 231)

No.	Item	Mean Frequency	Mean Intensity	Frequency × Intensity (fxi) Scores
1	I provide less than optimal care due to pressures from administrators or insurers to reduce costs	3.14	3.20	10.04
2	I witness healthcare providers giving false hope to a patient or family	3.19	3.53	11.26
3	I follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient	3.30	3.80	12.54
4	I initiate extensive life-saving actions when I think they only prolong death	3.48	3.20	11.14
5	I follow the family's request not to discuss death with a dying patient who asks about dying	3.35	3.46	11.59
6	I carry out the physician's orders for what I consider to be unnecessary tests and treatments	3.00	3.30	9.90
7	I continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support	3.52	3.20	11.28
8	I avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it	3.35	3.35	11.21
9	I assist a physician who, in my opinion, is providing incompetent care	3.33	3.11	10.36
10	I am required to care for patients I do not feel qualified to care	3.16	3.31	10.46
11	I witness medical students perform painful procedures on patients solely to increase their skill	3.10	3.30	10.23
12	I provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death	3.26	3.36	10.95
13	I follow the physician's request not to discuss the patient's prognosis with the patient or family	3.36	3.35	11.27
14	I increase the dose of sedatives or opiates for an unconscious patient that I believe could hasten the patient's death	3.33	3.16	10.53
15	I take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing	3.35	3.30	11.06
16	I follow the family's wishes for the patient's care when I do not agree with them but do so because of fears of a lawsuit	3.13	3.80	11.89
17	I work with nurses or other healthcare providers who are not as competent as the patient care requires	3.19	3.15	10.05
18	I witness diminished patient care quality due to poor team communication	3.22	3.42	11.02
19	I ignore situations in which patients have not been given adequate information to insure informed consent	3.07	3.20	9.81
20	I watch patient care suffer because of a lack of provider continuity	3.28	3.07	10.07
21	I work with levels of nurse or other care providers that I consider unsafe	3.23	3.30	10.66
COMPOSITE SCORE (Interpretation- High Moral Distress)				**227.31**

Legend: 169-336 (High Moral Distress), 85-168 (Moderate Moral Distress), 0-84 (Low Moral Distress)

Table 6 Relationship between moral caring competency and moral distress (*N* = 231)

Spearman's rho		Moral Caring Competency	Moral Distress
Moral Caring Competency	Correlation Coefficient	1	-0.474**
	Sig. (2-tailed)	.	<0.001
	N	231	231
Moral Distress	Correlation Coefficient	-0.474**	1
	Sig. (2-tailed)	<0.001	.
	N	231	231

Note: **. Correlation is significant at the 0.01 level (2-tailed)

Discussion

The findings of the study revealed that Ghanaian nurses had an overall low level of moral caring competency (M = 2.18, SD = 0.340), suggesting that the nurse respondents of this study may lack the ability to address moral issues in patient care. This study's finding affirms an array of literature in which the studies showed low moral caring competency among nurses (Adhikari et al., 2016; Clark et al., 2021; Kalvemark Sporrong, 2007). These previous studies identified a lack of nursing professional development, poor enforcement of clinical policies, and minimal organizational support as the primary causes for their low level. On the contrary, research conducted among nurses in New Zealand (Water et al., 2017) and Botswana (Barchi et al., 2014) indicates that moral competency was relatively high due to continuous ethics in-service training.

In the Ghanaian context, the nurse respondents' low level of moral caring competency can be attributed to the varying results demonstrated in the subdimensions: moral sensitivity, judgment, motivation, character, and decision-making. Based on the study's findings, the nurses had a low moral sensitivity level (M = 2.29, SD = 0.520). The existence of diverse subcultures in Ghana may pose challenges for nurses to be

morally sensitive and recognize certain situations as moral dilemmas due to the lack of cultural awareness of the patients (Kwamie et al., 2017). The nurses had a very low moral judgment level (M = 1.76, SD = 0.432). The constantly elevated degree of stress and burnout experienced (56.3%) among Ghanaian nurses has the potential to impact their cognitive abilities (Opoku et al., 2022), which may significantly compromise their moral judgments.

Furthermore, the study's results revealed that nurses had a moderate (M = 2.63, SD = 0.845) level of moral motivation. Ghanaian nurses see the relevance of the code of ethics in certain morally challenging situations; however, in other cases, their cultural beliefs and practices influence the way that they respond to these issues in practice (Oulton, 2000). Likewise, the nurses had a moderate moral character level (M = 2.72, SD = 0.752). The nurses' fear of repercussions for being assertive and morally courageous may impact their confidence and willingness to exercise their moral character and advocate on behalf of their patients (Siaw-Frimpong et al., 2021). As per the study's findings, the nurses had a low moral decision-making level (M = 2.01, SD = 0.415). Addo et al. (2020) and Ahenkan et al. (2018) studies discovered that there is a lack of mentorship among nurses within public hospitals, in which novice nurses may rely on their limited personal perspectives, potentially leading to morally questionable decisions.

The high level of moral distress (composite score = 227.31) suggests that the nurses in public hospitals experience increased psychological discomfort due to the complex moral dilemmas they confront while providing patient care. The findings are congruent with prior studies (Afoko et al., 2022; Berhie et al., 2020; Sirilla et al., 2017), attributing their findings to work overload, inadequate resources, and poor administrative support. However, other studies showed that nurses with extensive clinical work experience had resilience, resulting in a moderate to low pooled estimated score of moral distress (Alimoradi et al., 2023; Nikbakht Nasrabadi et al., 2021). In Ghana, moral distress among nurses arises from various clinical sources and scenarios, including family-based moral issues, nurse-physician challenges, and organizational constraints. In particular, Donkor and Andrews (2011) discovered that moral distress commonly occurs among Ghanaian nurses when they encounter the intricate interplay of family dynamics, fear of lawsuits, and the difficult decisions that emerge in end-of-life care scenarios involving patients.

Lastly, the study suggests that moral distress decreases when Ghanaian nurses' moral caring competency increases, indicating an inverse correlation. Therefore, boosting the moral caring competency of nurses in public hospitals could potentially mitigate their experience of moral distress. This result is in accordance with previous studies (Cerit & Dinç, 2013; Davis et al., 2012; Kalvemark Sporrong, 2007). In contrast, Atashzadeh-Shoorideh et al. (2021) and Sedaghati et al. (2020) yielded no significant relationship between moral caring competency and moral distress, attributing the results to organizational factors such as administrative support, adequate resources, positive nurse–physician relations, significantly correlates with moral distress among nurses. Morally competent nurses have enhanced knowledge, skills, and attitudes in navigating moral complex clinical situations, with a greater ability to manage moral distress and its repercussions (Bayat et al., 2019). However, moral distress arises when nurses fail to possess an adequate moral caring competency to engage in moral grounded decision-making and execute suitable actions anchored in moral-based standards (Corley et al., 2001).

Corley's Moral Distress Theory, serving as the theoretical framework for this study, affirms the correlation between the two variables. According to Corley et al. (2001), nurses with high moral caring competency are more likely to experience less moral distress. In other words, moral distress occurs when nurses lack the moral caring competency required to make morally informed decisions and take appropriate moral-based actions (Corley et al., 2001). Therefore, it is imperative to understand the significance of moral caring competency in mitigating moral distress, as this has implications for patient care, nurses' well-being, and the healthcare institution (Corley et al., 2001).

Limitations of the Study

Despite yielding notable findings, this research study had its limitations. The research was carried out in three public health facilities in Ghana. Hence, the generalizability of the findings cannot be generalized beyond public hospitals.

Implications and Recommendations

Nurses in public hospitals have a limited personal affective, cognitive, and psychomotor ability to address patients' moral issues and experience significant moral distress. Practicing nurses' awareness of their levels of moral caring competency and moral distress holds significant implications for individual well-being and patient care quality. Recognizing low levels of moral caring competency would encourage a proactive approach towards professional development and training, ensuring continuous improvement of nurses' moral decision-making for their patients. Similarly, a comprehensive understanding of their high moral distress would enable the nurses to identify and address the root causes of the moral issues encountered in their clinical units.

It is recommended that nurse administrators implement targeted interventions to offer organizational support and empowerment initiatives focusing on improving public nurses' moral caring competency. Ghanaian nurses should actively participate in continuous ethics and moral training sessions and engage in support systems, including regular debriefing sessions and counseling services, to mitigate their moral distress levels and maintain their overall well-being. Policymakers are encouraged to develop or refine policies that support the cultivation of moral caring competency and reduce moral distress among Ghanaian nurses. Future studies employing qualitative designs can explore the influence of culture on moral caring competency within the Ghanaian setting. In addition, studies should be conducted in other hospital institutions in Ghana to understand the current level of moral caring competency and moral distress.

Conclusion

As frontline caregivers, nurses encounter moral issues while delivering patient care daily. A review of previous scholarly studies revealed a dearth of research concerning moral caring

competency and moral distress among Ghanaian nurses, indicating a gap in understanding within this field of study. Based on the study's findings, in order to address moral issues in patient care with efficacy, it is crucial to strengthen the moral caring competency of nurses within public hospitals in Ghana. This, in turn, would mitigate the substantial moral distress experienced by these nurses.

Declaration of Conflicting Interest

The authors have declared no conflict of interest in this study.

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Authors' Contributions

RA and JG made substantial contributions to conceptualizing the topic area, literature review, data collection and interpretations, revisions, and preparation of the final version. RA and JG approve of the final version to be published. RA and JG agree to be accountable for all aspects of the work.

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Data Availability

The datasets generated and analyzed during the current study are available from the corresponding author upon reasonable request.

Declaration of Use of AI in Scientific Writing

There is nothing to disclose.

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