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Investigating the relationship between missed/rationed nursing care and organizational commitment in Iranian nurses

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Abstract

Background and objective The primary objective of the nursing profession is to provide comprehensive and appropriate nursing care that meets the individual needs of patients. However, instances of missed/rationed nursing care can jeopardize the delivery of complete and safe healthcare, potentially putting patients' lives at risk. The level of organizational commitment demonstrated by nurses is likely to impact various personnel and organizational factors. Therefore, this study aims to predict instances of missed/rationed nursing care by examining the influence of organizational commitment.

Method This descriptive and cross-sectional study will be conducted in 2023. Three hundred nurses working in general and intensive critical care units at Tehran University of Medical Sciences hospitals were randomly selected. Data collection included Allen and Mayer's organizational commitment questionnaires, Kalish's missed care questionnaire, and demographic variables. A multiple linear regression model was used to analyze the prediction of missed care by commitment and other variables. The relationship between these variables was also explored using SPSS version 26 software.

Findings Half of the nurses reported occasionally missing nursing care. Moreover, more than half of the nurses reported moderate organizational commitment in all dimensions. The most significant reasons identified by nurses for missed care were financial resources, human resources, and communication ($p < 0.001$). There was a significant relationship between missed/rationed nursing care and organizational commitment ($p = 0.042$). In the multiple regression equation, a significant portion of missed care due to commitment was predicted when considering demographic variables ($p < 0.001$).

Conclusion By understanding the relationship between organizational commitment and missed care, and identifying the factors contributing to missed/rationed care, managers can improve the efficiency of human resources and allocate appropriate financial resources. Establishing effective communication with employees can also enhance their commitment to addressing neglected care, ultimately reducing instances of oversight.

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Introduction

The primary objective of nursing is to provide comprehensive nursing care based on patient needs [1]. Nursing care encompasses skilled, safe, high-quality, and ethical practices designed to support patient health, symptom relief, or peaceful death. Ensuring the quality of nursing care and patient health poses a fundamental challenge for nursing managers [2].

In recent years, there has been renewed interest in essential nursing care [3], with researchers recognizing that care can be missed [1]. Missing nursing care was initially conceptualized in the first qualitative study by Kalish in 2006 in the United States [2]. Missed/rationed nursing care refers to any part of necessary patient care that is partially or completely omitted by the nurse [4]. This omission or error in care can be life-threatening according to international patient safety and quality standards [5, 6].

Despite an increase in studies on missed care [1], making meaningful comparisons between studies, settings, and healthcare systems remains challenging [7]. Additionally, the concept of "rational care" has yet to be fully theorized [8]. The studies conducted on missed care so far have mostly been in developed countries and differ significantly from the current study in terms of the care and training context of nurses, as well as the number and composition of human resources. Many of these studies have also not explored the relationship between this variable and organizational commitment. Therefore, more extensive and further research in this field is needed in Iran and other developing countries.

Missed/rationed care is a complex concept that has posed challenges for managers and other employees particularly within the nursing system [9]. The outcomes linked to missed/rationed nursing care include diminished overall quality of patient care, heightened patient side effects [10–12], prolonged hospital stays [12], increased rehospitalization rates and even mortality [13, 14]. These consequences also lead to reduces job satisfaction among nurses and lower levels of patient satisfaction [1, 13]. Therefore, in order to mitigate these risks, it is imperative to delve deeper into the study and understanding of missed care and the factors that influence it.

Nurses are the most significant and crucial human resources in hospitals. Despite instances of missed or rationed care, it is important to acknowledge the potential impact on nurses themselves. Prolonged time pressure can lead to decreased job satisfaction, an increased risk of job burnout, and higher employee turnover rates [12, 15]. Articles have also observed that missed nursing care increased during stressful time such as the COVID-19 pandemic [16]. Furthermore, evidence suggests that missed or rationed nursing care can have negative consequences at both the individual patient and organizational levels [7, 15, 17].

When nurses are unable to provide comprehensive and high-quality patient care in hospitals, it not only jeopardizes patient safety but also leads to increased healthcare costs. Therefore, identifying and addressing the issue of missing or rationed nursing care is crucial for improving healthcare quality [6]. The penalties associated with such shortcomings for both patients and organizations [14, 18, 19] further emphasize the need to investigate the factors contributing to these occurrences. Previous studies have identified various factors that influence missed or rationed care, including those related to human resources [1, 20, 21], communication [1, 21], material resources [1, 21], and structural factors [20, 22]. Due to the relationship between missed/rationed care and the quality of care, this phenomenon is considered an important issue in the health system. However, there are still very few studies in this field. Meanwhile, the high prevalence of missed/rationed care endangers patient safety and reduces the quality of care.

Human resources play a significant role in achieving an organization's goals, and managers recognize that this factor is key to gaining a competitive advantage [23]. Nurses are among the most vital human assets in a hospital, as the success of the organization heavily relies on their commitment [24]. Nurses who exhibit high organizational commitment can deliver high-quality care even in stressful work environments and with limited resources [25]. The most famous studies related to organizational commitment were conducted by Allen and Mayer, who identified three dimensions of organizational commitment: emotional, continuous, and normative. Emotional commitment refers to the emotional attachment, identification, and involvement of workers in the organization, aligning with its values and goals. Normative commitment reflects a sense of duty and moral obligation to remain in the organization. Continuous commitment represents an understanding of the costs and consequences associated with leaving the organization [26].

Employee commitment to the organization results in numerous positive outcomes, including increased discipline at work and a desire to stay with the organization. Conversely, a lack of organizational commitment leads to increased job turnover, absenteeism, tardiness, and decreased performance, all of which negatively impact organizational effectiveness and efficiency [27]. Since nurses are the most significant human capital in

hospitals, it is crucial to focus on their level of commitment. Decreased organizational commitment among nurses has been associated with higher rate of absenteeism, low job motivation, decreased nurse performance, and, consequently, reduced quality of care and hospital efficiency [28]. Organizational commitment is especially crucial for the performance and productivity of healthcare organizations [29]. In today's world, managers are increasingly concerned with the commitment and loyalty of their employees to the organization. This includes their ability to perform their assigned roles and even go above and beyond with extra-role tasks. Therefore, there is a growing need to investigate and address issues related to organizational commitment.

Despite existing research on both missed or rationed care and organizational commitment, these two vital management components have not been studied together yet. Enhancing organizational commitment and improving nursing care quality are key responsibilities of operational managers, such as head nurses and supervisors. By focusing on missed care and organizational commitment, unnecessary financial expenses can be avoided, and strategies for managers can be developed. Therefore, this study aims to predict missed or rationed care based on commitment and other variables to inform managers and nurses on how to enhance the quality of healthcare services.

Methods

This descriptive and cross-sectional study was conducted in 2023 at the general and critical care units of Tehran University of Medical Sciences hospitals. A random stratified sampling method was used to select nurses from these units in general hospitals. The sample size was determined using G*Power software, considering $\alpha=0.05$, a study power of 0.80, and the multiple linear regression model with the fixed effect model. Since there were up to five other independent variables, in addition to organizational commitment, entering the model as contextual variables, and the multiple models had an R^2 value of 0.05, the sample size was calculated to be 266 subjects. Considering the possibility of 10% incomplete questionnaire, the sample size was estimated to be 300.

The information required for this study was gathered through the use of the self-report technique and a questionnaire that was divided into four sections. The first section collected demographic information, while the second section assessed missed/rationed nursing care using Kalish's scale, which included 24 items rated on a 5-point Likert scale [30]. The third section evaluated the reasons behind missed nursing care based on Kalish's scale (2006), and the fourth section contained the organizational commitment questionnaire created by Allen and Mayer (1993) [31].

Questions regarding demographic information such as gender, age, marital status, number of children, education level, work history, employment type, position, shift schedule, required monthly working hours, mandatory or optional overtime, amount of overtime worked in a month, absences in the past year, and number of days absent were included.

The missing/rationed care measurement questionnaire consists of 24 items, each rated on a Likert scale from one to five. Response options include "never forget, rarely forget, sometimes forget, frequently forget, and always forget." A response of "I never forget" is scored as one, while "I always forget" is scored as five. A higher score indicates more lost or rationed care, while a lower score indicates less care is lost or rationed.

The questionnaire assessing causes related to lost/rationed care contains 20 items, scored on a Likert scale from one to four. Response options are "unimportant," "low importance," "medium importance," and "high importance." An answer of "unimportant" receives a score of one, while "high importance" receives a score of four. A high score from the respondent indicates greater importance of the mentioned reason, while a low score indicates lower importance. The questionnaire dimensions are divided into human resources (9 questions), material resources (3 questions), and communication (7 questions).

The Organizational Commitment Questionnaire consists of 24 statements designed in three dimensions: emotional commitment (statements 1 to 8), continuous commitment (statements 9 to 16), and normative commitment (statements 17 to 24). Each statement is rated on a Likert scale from one to five, with response options ranging from "I completely disagree" to "I completely agree." A score of one is assigned to "totally disagree" and a score of five is assigned to "totally agree." The lower the score a respondent receives on the questionnaire, the lower their commitment level; the higher the score, the higher their commitment level.

Before collecting the data, the validity of the questionnaires was evaluated and approved by sending them to the emails of several expert professors from the Tehran University of Medical Sciences, who specialize in nursing management.

To measure reliability, thirty questionnaires were distributed among the nurses. The results were calculated using Cronbach's alpha coefficient. The first part of the questionnaire, which measured missed/rationed care, had an alpha coefficient of 0.97. Similarly, the second part, which measured the causes of missing care, had an alpha coefficient of 0.97. The commitment questionnaire had an alpha coefficient of 0.85.

After receiving approval from the Joint Committee of Organizational Ethics (code: IR.TUMS.FNM.

Table 1 Frequency distribution of missed/rationed care from the point of view of nurses participating in the research

Missed/rationed care	Frequency	Percent
< 25	79	26.3
25–48	68	22.7
49–72	142	47.3
73–96	11	3.7
> 96	0	0
Mean ± standard error	43.59 ± 16.47	
Range	24–81	

REC.1401.09) and obtaining the necessary permits, the researcher introduced herself to the nursing managers at each hospital. The researcher received a list of qualified nurses from them and then contacted the nurses. After explaining the study's objectives, she asked the nurses to participate. If they agreed, the researcher personally provided them with the questionnaires and then waited for the completion and collection of responses. It took nurses approximately 15 min to complete the questionnaires, which they did while at the hospital.

The data collection process took three months to complete. Once collected, the data were entered into SPSS software (version 26) for analysis. Numerical, continuous, and discrete data were reported with their mean and standard deviation, while nominal or ranked data were reported as raw and relative frequencies.

When assessing the relationship between the score of missed/rationed nursing care as the dependent variable and organizational commitment as the independent variable, we first examined the assumptions of linear regression analysis. After confirming that these assumptions were met, we utilized the linear regression model to show the correlation between the desired variables using the β coefficient.

Findings

The findings revealed that, in terms of frequency, half of the nurses occasionally missed nursing care. A quarter of nurses have never missed care, and only small number report frequent instances of missed care. The primary reasons identified by nurses for missed care are financial resources ($p<0.001$), human resources ($p<0.001$), and communication ($p<0.001$), as shown in Table 1.

According to the study results, approximately half of the nurses (47.33%) had an average level of emotional commitment, about two-thirds of the participating nurses (58.3%) had an average level of continuous commitment, and more than half of the nurses (51.7%) expressed an average level of normative commitment. Finally, the majority of nurses (63%) reported moderate organizational commitment.

Table 2 displays the multiple linear regression equation that examines the relationship between missed care and different levels of commitment. It was found that missed care is significantly related to organizational commitment, with higher levels of commitment resulting in less missed care. Additionally, missing care is significantly related to the dimension of normative commitment.

Regarding relationship between missed care and demographic variables, the following results were obtained:

Missed/rationed care showed a significant relationship with variables such as age, marital status, work experience, type of official employment, special department, emergency department, position, rotating shift, long day shift and evening and night shift, working hours per month, extra work, lack of planning according to request, lack of sufficient manpower in the department, low job satisfaction, average job satisfaction, and average satisfaction with the activity in the current department. Table 3 provides the details of the multiple linear regression equation for missed care and demographic variables as well as normative commitment in nursing, which also shows a significant relationship.

Missed care was assessed based on various variables, including age, marital status, work experience, type of official employment, type of ward (general, critical care units, or emergency department), position, shift, working hours per month, amount of overtime, scheduling based on their request, staff in the ward, job satisfaction, and

Table 2 Multiple regression equation for causes of missed/rationed care (human resources, financial resources, communication)

Causes of missed/rationed care	regression coefficient	standard error	beta coefficient	statistical significance
Human resources	-0.93	0.15	-0.32	$P<0.001$
Financial resources	-2.78	0.42	-0.35	$P<0.001$
Communications	-1.48	0.17	-0.43	$P<0.001$

Table 3 Regression equation for missed care with organizational commitment and three components: emotional, continuous, and normative commitment

missed/rationed care	regression coefficient	standard error	beta coefficient	statistical significance
Organizational commitment	-0.13	0.06	-0.11	$P=0.042$
Emotional commitment	-0.26	0.15	-0.10	$P=0.08$
Continuous commitment	-0.009	0.18	-0.003	$P=0.975$
Normative commitment	-0.045	0.15	-0.16	==0.003

average satisfaction with the activity in the current ward. These factors showed a significant relationship with missed care ($p<0.05$). Table 4 provides more details on the multiple linear regression equation used to analyze the relationship between missed care and demographic variables, as well as the normative commitment of nursing, which was also found to be significant.

The average age of the nurses was 34±7.06 years. 88% of them were women and 60% were married. A total of 33.85% had a bachelor's degree, while 12% had a master's degree or higher. Among them, 44% worked in the medical-surgical department, 41.3% in critical care, and 14.67% in emergency departments. The average experience of the participants was 10.08±6.6 years. Additionally, 78% worked as a nurse, and 5.67% worked as a head nurse. A total of 43.7% had rotated shifts, and 24.7% worked in the morning. More than half of the samples (53%) were employed formally. The average working hours per month were 167 h, with 86 h of overtime. A total of 88.3% reported that their overtime was mandatory. The majority (84%) of the samples had a second job to make ends meet. Furthermore, 94% stated that the monthly schedule was set according to their request. A total of 91.7% mentioned that they had not been absent in the last year. Only 25 people (8.3%) mentioned that they had been absent, and in half of those cases, the absence was only for one day. A total of 33.60% mentioned that there were insufficient personnel in the ward, while 37% said it was somewhat sufficient. Additionally, 33.40% of those intended to leave the job, while 67.59% did not.

Table 1 shows the frequency distribution of missed/rationed care from the nurses' perspective.

Table 2 demonstrates the significant relationship between all three causes (human resources, financial resources, communication) and missed care.

Table 3 highlights a significant relationship between missed care and organizational commitment, particularly in the dimension of normative commitment.

Table 4 outlines the correlation between missed care, demographic variables, and normative commitment.

Discussion

The main purpose of this study was to describe missed nursing care and its causes, as well as to examine the commitment of nurses. The researchers also aimed to determine the relationship between these variables. However, there were very few studies that examined the relationship between these two variables, which have been discussed in this section.

The findings of this study revealed that half of the nurses sometimes missed nursing care. Another study by Chegini (2020) found that the prevalence of missed/rationed care in Iran was 57.2% [6]. Studies conducted in other countries have explored the variations in the prevalence of missed care among different nations. For instance, Simonetti et al. (2022) discovered that the prevalence of missed care in Chile was 86% [32]. Similarly, the prevalence in the United States was found to be 81% [5] and 74% in Brazil [33]. The missed care in Turkey was reported as 2.93 on a scale of 1 to 4 which was considered high [34].

The differences in the rate of missed/rationed care in our study compared to the aforementioned studies can be attributed to significant differences between Iranian hospitals tasks and those in other countries. For example, in Iran, several care tasks, such as bathing and cleaning patients, are the responsibility of nurses' aides rather than nurses themselves. Additionally, nurses in Iranian hospitals often decline to report their poor performance due to existing policies and the prevailing cultural atmosphere in the wards. Furthermore, the lack of knowledge and understanding among nurses and managers regarding missed/rationed care may be one of the factors affecting nurses' responses.

According to the results obtained in the present study, there is a significant relationship between the causes of missed/rationed care and the level of missed care ($p<0.001$). The most important reasons identified by nurses for missed care are financial resources ($p<0.001$), communication ($p<0.001$), and human resources ($p<0.001$). A parallel study by Lee (2021) that identified

Table 4 Correlation between missed care, demographic variables, and normative commitment

missed/rationed care		regression coefficient	standard error	beta coefficient	statistical significance
Normative commitment		-0.24	0.13	-0.08	P = 0.08
Marital status	married	-3.78	1.78	-0.11	P = 0.034
	divorced	2.059	8.21	0.12	P = 0.013
Work experience		-0.57	0.14	-0.23	P < 0.001
Ward	Critical	-4.86	1.72	-0.14	P = 0.05
	Emergency	13.56	2.37	0.29	P < 0.001
position	Head nurse	-7.67	3.9	-0.10	P = 0.050
	First nurse	-5.39	2.7	0.09	P = 0.047
	Responsible of shift	-6.95	3.59	-0.10	P = 0.054
The presence of students in the ward		9.02	1.73	0.25	P < 0.001

and compared missing nursing care in the United States and Korea was reported [35].

The most common reasons for missing nursing care in Korea were a shortage of nursing personnel, unexpected increase in the number of patients, emergency situations with patients, a lack of aide or secretarial staff, and a large workload of administrative tasks related to admission and discharge. Similarly, in the United States, the main reasons for missing nursing care included unexpected increases in patient numbers, a shortage of aide or clerical staff, patient emergencies such as worsening conditions, a high volume of administrative duties related to admission and discharge, and delays in receiving medications on time [35]. It is important to note that the reasons for missed nursing care vary among the three countries (Iran, United States, and Korea). However, all three countries reported human resource problems in general.

In the current study, Iranian nurses identified financial resources as a more significant cause of missed care compared to communication. This discrepancy can be attributed to the inadequate allocation of funds to hospitals, the absence of effective financial management principles, and the differing financial policies in Iran compared to other countries. Additionally, it is important to note that the prioritization of financial resources over communication can have detrimental effects on patient care and overall healthcare outcomes.

Studies have consistently shown that financial resources are the primary factor contributing to missed nursing care [36]. Chegini's study (2020) ranked the reasons for missed/rationed care in Iran as follows: human resources, material resources, and communication issues [6].

In the current study, Iranian nurses identified communication as a more significant cause of missed care compared to human resources. Lee's study found that Korean nurses faced more communication challenges than American nurses. Similarly, Turkish nurses, who had a lower staff ratio than their American counterparts, reported the need for increased financial resources, staff, and improved communication. In Lebanon, nurses reported communication problems and financial shortages [35]. The findings of the current study suggest that there is less emphasis on individual and intergroup communication and teamwork among nurses in Iran. Previous studies revealed a correlation between missed nursing care and communication, which included three parts: communication between doctors and nurses, communication among nurses, and communication between nurses and patients [37, 38]. Additionally, communication issues are a common factor contributing to adverse events in healthcare settings. Therefore, managers of Iranian hospitals should establish open communication channels between nurses and other personnel and provide practical opportunities for nurses to express their concerns and issues. These measures will help enhance teamwork and positive communication among nurses.

Almost all dimensions of commitment are reported at a moderate level. More than half of the nurses reported moderate organizational commitment. A systematic study (2022) revealed that 12% of the studies reported a high level of organizational commitment among nurses, while 50% reported a medium level, which is consistent with the findings of the present study [39]. The variation in high and medium levels of commitment can be attributed to the measurement of different factors that influence nurses' organizational commitment. As there are various factors that contribute to improving employees' organizational commitment, it is necessary for managers to enhance nurses' attachment and commitment to the organization by considering factors such as delegating authority, clarifying responsibilities, and accurately evaluating employee performance.

The studies [39, 40] along with the present study, have found that the level of commitment among nurses is moderate. However, the results of the present study indicate that the organizational commitment of nurses is not at an optimal level and needs improvement. To prevent nurses from leaving their positions and to enhance the quality of nursing care, managers in the healthcare system should take into account individual and organizational factors that influence organizational commitment, particularly job satisfaction. They should make efforts to increase the organizational affiliation of nurses.

Among the reasons why the level of commitment of nurses in our study was found to be moderate, several factors were mentioned, including levels of responsibility and autonomy, ethics, culture, and organizational performance in their workplace. In Iranian hospitals, nurses have limited freedom of action and autonomy, which can lead to lower levels of commitment over time and a sense of worthlessness in their work. Additionally, ethics and organizational culture play a significant role in nurses' commitment levels. Organizations that prioritize meritocracy in hiring and promoting, organizational performance in workplace, participating in the performance appraisal process, and empowerment for nurses tend to have higher levels of organizational commitment among employees [28, 41–43].

Hendy study (2024) findings highlight the significant role of professional commitment as an intermediary factor between the working environment and reducing missed nursing care [9].

Nursing managers play a crucial role in this process. Health managers and policymakers who possess effective leadership skills, the ability to influence others, fair compensation practices, strategic decision-making abilities, motivation-building techniques, and appropriate policies

can enhance employee commitment and improve organizational performance quality [44]. According to the results obtained from this study, there is a significant relationship between missed/rationed care and organizational commitment. The findings indicate that individuals with higher levels of commitment are less likely to miss care ($p=0.042$). Specifically, the dimension of normative commitment was found to be significant in relation to missed/rationed nursing care ($p=0.003$). These results align with Cho's study (2021) [45], which also found that increased commitment leads to improved care standards [46]. Similarly, other studies have revealed that higher levels of commitment are linked to a decrease in missed care incidents [45].

Conclusion

In the present study, organizational commitment was found to have a significant relationship with missed/rationed care. However, this relationship was only significant in the dimension of normative commitment, suggesting that nurses in Iran are committed to their jobs and providing nursing care. The study also highlighted the low levels of continuous and emotional commitment among nurses, emphasizing the need to investigate the causes and barriers to commitment.

To address the issue of missed/rationed care and improve the quality of services, it is important for managers to be aware of this concept and for care and health leaders to share their experiences and knowledge in brainstorming sessions. This collaboration can lead to the development of effective solutions and strategies to reduce missed/rationed care.

Limitations

In this study, the samples were taken from general hospitals. There is a possibility that single specialty hospitals may yield different results. Therefore, future studies are recommended to compare the findings of this study with those of private and single-specialty hospitals.

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Author contributions
FB collected the data and wrote the manuscript. NDN supervised the thesis and controlled the entire process, including editing the manuscript. FH provided consultation for the thesis and assisted with interpretation. FSH analyzed the data and provided feedback for the statistical section. All authors read and approved the final manuscript.

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Data availability
All data generated or analysed during this study are included in this published article.

Deceleration

Ethics approval and consent to participate
We obtain approval from the Joint Committee of Organizational Ethics of Tehran University of Medical Sciences. (Code: IR.TUMS.FNM.REC.1401.09). Informed consent was obtained from the nurses to participate in the study.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

No patient or public contribution
Our manuscript is a descriptive article, in which the necessary data was obtained by filling out a questionnaires, and at the beginning of the questionnaires, informed consent was obtained from the nurses to participate in the study. Participants were assured of the confidentiality of the information.
This study is not an interventional study, so did not require any intervention on nurses or patients or anyone else.

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