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Artificial Intelligence Literacy and Readiness Among Neonatal Nurses: A Structural Equation Modeling Study

Zübeyde Ezgi ERÇELİK

eozgen@bandirma.edu.tr

Bandırma Onyedi Eylül University

Diler AYDIN YILMAZ

Bandırma Onyedi Eylül University

Merve Nur ERYILMAZ TAŞ

Bandırma Onyedi Eylül University

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Abstract

Background

Neonatal Intensive Care Units represent high-risk clinical environments where timely and accurate decision-making is critical for newborn survival, increasing the demand for advanced technological support. As artificial intelligence becomes progressively integrated into neonatal care, it is transforming nurses' clinical workflows and decision-making processes, underscoring the need to understand their preparedness and perceptions regarding these technologies.

Aim

This is a cross-sectional and descriptive study to determine the artificial ıntelligence literacy and readiness of neonatal nurses.

Methods

This was conducted between August 2025 and January 2026, and included 200 neonatal nurses. Data were collected using sociodemographic information, the Artificial Intelligence Literacy Scale (AILS) and the Medical Artificial Intelligence Readiness Scale (MAIRS) and analyzed using structural equation modeling.

Results

Structural equation modeling supported H1, indicating that AILS significantly and positively predicted MAI-Readiness ($B = 0.662$, $p < .001$). AILS explained 57.3% of the variance in MAI-Readiness ($R^2 = 0.573$), demonstrating a strong effect.

Conclusion

This study provides empirical evidence that AI literacy is a significant determinant of AI readiness among neonatal intensive care nurses in Türkiye. The findings indicate that higher levels of AI literacy are associated with greater self-efficacy and willingness to integrate AI technologies into clinical decision-making processes. Healthcare institutions should prioritize structured AI literacy training programs for neonatal intensive care nurses to enhance their self-efficacy and readiness for integrating AI technologies into clinical decision-making processes, thereby ensuring sustainable and ethical AI adoption in high-risk care settings.

Clinical trial number

Not applicable.

INTRODUCTION

Artificial intelligence (AI) refers to computational systems developed for a wide range of applications that process and analyze data from diverse sources. Through iterative learning and self-improvement mechanisms, these systems enhance their performance over time, thereby reducing dependence on human intervention [1]. AI technologies are increasingly being integrated into clinical decision support systems, patient monitoring, diagnostic procedures, and personalized treatment planning [2]. In nursing practise, AI applications promise to enhance clinical decision-making, simplify documentation, and alleviate workload pressures. These applications hold significant potential to enhance healthcare outcomes and improve the efficiency of resource utilization [3].

Although global research has increasingly focused on AI adoption in healthcare, its application within neonatal care remains relatively unexplored [3]. Despite significant progress in neonatal and perinatal care, newborn mortality remains a major global concern, with an estimated 2.3 million infants dying within the first month of life in 2023 [4]. Neonatal nurses provide critical care in high-risk Neonatal Intensive Care Units (NICUs), where accurate and timely clinical decisions are vital to newborn survival and development [5]. Traditionally guided by clinical expertise and protocols, these decisions are now increasingly supported by artificial intelligence (AI), which is transforming data interpretation and care delivery in neonatal settings [6].

AI applications used in NICUs can predict a high or increasing risk of clinical deterioration resulting from a disease similar to sepsis [7]. McAdams et al. stated that these applications could be implemented in neonates with bronchopulmonary dysplasia and may help regulate sleep disturbances observed in these patients [8]. These applications optimize workflows, reduce human error and enhance diagnostic accuracy [5]. In the NICU, nurses are required to respond quickly and accurately to critically ill infants, making this environment highly sensitive to technological malfunctions [3]. However, the integration of new technologies into these high-risk settings raises important questions regarding nurses' perceptions of these tools, their level of trust, concerns about staff oversight, potential misuse, patient safety, and bias [9].

The burden of neonatal morbidity and the complexity of caring for premature or critically ill infants pose significant challenges for NICU nurses [10]. These challenges may increase the need for AI support in the field. Artificial intelligence literacy encompasses the fundamental knowledge, technical skills, and ethical awareness necessary to understand, critically analyze, and effectively utilize artificial intelligence technologies in clinical and educational settings [11]. Artificial intelligence readiness refers to the knowledge, skills, and awareness individuals need to use artificial intelligence technologies effectively [12]. It is especially important for ensuring professional competence in healthcare, particularly in nursing

and patient care [13]. The collaboration between nurses and AI systems requires more than simple adoption; it involves actively interpreting the information produced by AI, using it in clinical decision-making, and maintaining essential human supervision. Nurses may also contribute to the ongoing development and improvement of AI tools by providing feedback to ensure that these technologies genuinely support patient-centered care [14].

Although artificial intelligence is rapidly becoming integrated into many areas of daily life, there remains a significant gap in research examining the perceptions of NICU nurses toward AI, especially as its application in healthcare continues to expand. This foundational, descriptive, and exploratory study aims to assess NICU nurses' artificial intelligence readiness and literacy levels.

METHODS

Research design

This study was conducted using a cross-sectional and descriptive design. Structural equation modeling (SEM) was employed to comprehensively examine the direct and indirect relationships among the study variables. The study was reported on according to STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) guideline [15].

Setting and Participants

The study included neonatal intensive care nurses working in neonatal intensive care units across Turkey, and data collected via questionnaires from 200 nurses who met the inclusion criteria between August 2025 and January 2026 were included in the sample.

Inclusion and exclusion criteria

Inclusion criteria

- Being employed as a neonatal intensive care nurse in neonatal intensive care units of university hospitals, city hospitals, private/foundation hospitals, or state hospitals across Turkey
- Providing voluntary consent to participate in the study
- To fill in the research data completely and accurately.

The required sample size was determined using G*Power 3.1 in accordance with prior literature [16]. To test the power of the sampling method, a calculation was made using G*Power, accepting an effect size of 0.5, a power of 0.80, and an alpha of 0.05, which determined that a minimum of 108 nurses should be reached [17]. The study reached 200 nurses.

Hypothesis

Based on the study aims and existing literature, the following hypothesis was tested:

H1: Neonatal nurses' artificial intelligence literacy levels positively influence their artificial intelligence readiness.

Data Collection Tools

Study data were collected via a questionnaire that included a "Sociodemographic Information" the "Medical Artificial Intelligence Readiness Scale," and the "Artificial Intelligence Literacy Scale". Permissions to use the scales, which have established high reliability, were obtained [18, 19].

Sociodemographic Information

The form developed by the researchers based on the literatüre [16, 20]. consisted of a total of 16 items assessing nurses' sociodemographic characteristics (e.g., age, gender, education level) as well as their level of artificial intelligence knowledge, prior training, and use of artificial intelligence applications.

Medical artificial intelligence readiness scale (MAI-readiness): The Medical Artificial Intelligence Readiness Scale, developed by Karaca et al., consists of 22 items and four sub-dimensions: cognitive (8–40 points), skill (8–40 points), foresight (3–15 points), and ethical (3–15 points) [18]. Each item is rated on a 5-point Likert-type scale, with total scores ranging from 22 to 110. Higher scores indicate greater medical artificial intelligence readiness. In the original study by Karaca et al., the Cronbach's alpha coefficient for the total scale was reported as 0.87 [18], whereas in the present study it was calculated as 0.95.

Artificial Intelligence Literacy Scale: In this study, the Artificial Intelligence Literacy Scale (AILS), originally developed by Wang et al. [21] and adapted into Turkish by Çelebi et al. was used [19]. The scale consists of a total of 12 items across four subdimensions: Awareness (three items), Use (three items), Evaluation (three items), and Ethics (three items). The Awareness subdimension assesses participants' understanding and recognition of artificial intelligence technologies. The Use subdimension evaluates the extent to which individuals utilize artificial intelligence applications in practice. The Evaluation subdimension measures participants' ability to critically assess the effectiveness and reliability of artificial intelligence systems. The Ethics subdimension examines sensitivity to ethical considerations related to artificial intelligence technologies. The scale is a 7-point Likert-type instrument with response options ranging from "strongly agree" to "strongly disagree." The possible total scores range from 12 to 84, with higher scores indicating greater artificial intelligence literacy. The scale includes reverse-scored items within the Awareness, Use, and Ethics subdimensions. In the original validation study, reliability and validity were assessed using Cronbach's alpha, composite reliability (CR), average variance extracted (AVE), and the heterotrait–monotrait ratio (HTMT). The reported Cronbach's alpha coefficients ranged between 0.73 and 0.83, CR values ranged from 0.73 to 0.88, AVE values ranged from 0.48 to 0.55, and

HTMT values ranged from 0.30 to 0.78, indicating acceptable psychometric properties. Model fit indices were reported as CFI = 0.99, TLI = 0.99, RMSEA = 0.01, and SRMR = 0.03. In the present study, the Cronbach's alpha coefficient for the total scale was found to be 0.82.

Data Collection

Data were collected following approval from the relevant ethics committee. An online survey was administered via Google Forms, specifically designed for neonatal intensive care unit (NICU) nurses. Participants were reached through face-to-face meetings and WhatsApp communication channels. Additionally, since the study targeted only NICU nurses, the survey link was shared in a dedicated WhatsApp group of NICU nurses affiliated with the Child Nursing Association, ensuring access to participants who met the target sampling criteria.

Informed consent

was obtained from nurses who agreed to participate, emphasizing that participation was entirely voluntary. The average time required to complete the questionnaire was approximately 15 minutes.

Data analysis

PSPP Version 2.0.0 was used for data analysis within the scope of the study, while the JAMOVI version 2.6.17 package program and SEM 1.1.6 add-on were used for Structural Equation Modeling analyses. Statistical significance level was accepted as $p < 0.05$. The role of scale mean scores on each other was evaluated by looking at the standardized regression coefficients (CMIN/DF, RMSEA, GFI and CFI values were checked to evaluate the validity of the model [22].

RESULTS

The mean age of the neonatal nurses participating in the study was 29.65 ± 5.90. In the study, 96% of the 200 neonatal nurses participating were female (n = 192). Most participants (55%) were single, 62.5% had a bachelor's degree, and 36.5% had 1–5 years of professional experience. Thirty percent of the participants worked in a teaching research hospital. Among the nurses, 6.5% had received artificial intelligence training (n = 13), and 13% (n = 26) used artificial intelligence applications in neonatal clinics. Table 1 presents data on the participants' sociodemographic characteristics.

Table 1
Descriptive statistics of socio- demographic variables of participants (n = 200)

Variables	$\bar{x}$	**sd**
Age	29.65	5.90
	n	**%**
Gender		
Female	192	96
Male	8	4
Marital status		
Married	90	45
Single	110	55
Participants' educational status		
High school	15	7.5
Associate degree	24	12
Bachelorette	125	62.5
Postgraduate	36	18
Experience in neonatal care		
1–5 y	133	66.5
5 y ↑	67	27.5
Level of Neonatal Service Worked		
Level I	24	11,9
Level II	53	26,6
Level III	89	44,7
Level IV	34	16,9
Type of the institution		
Teaching and research hospital	60	30
University hospital	16	8
Private/foundation	49	24.5
State hospital	32	16
City hospital	43	21.5

Variables	$\bar{x}$	sd
Status of training on AI		
Yes	13	6.5
No	187	93.5
Use of Artificial Intelligence-Based Technologies in Neonatal Clinics		
Yes	26	13
No	174	87

The mean MAI-readiness score of the nursing students participating in the study was 70.21 ± 17.53; the mean AILS score was 60.29 ± 10.96. The mean scores according to the subscales of the scales are presented in Table 2.

Table 2
Descriptive Statistics of Scale Scores

Scale Scores	Mean ± sd	(Min - Max)
MAI-readiness	70.21 ± 17.53	22–110
Cogmitive	23.42 ± 6.48	8–40
Ability	27.37 ± 6.99	8–40
Vision	9.64 ± 2.82	3–15
Ethics	11.00 ± 2.83	3–15
AILS	60.29 ± 10.96	12–84
Awareness	14.47 ± 3.00	6–21
Usage	14.50 ± 3.37	5–21
Evaluation	14,91 ± 3.97	3–21
Ethics	16.45 ± 3.57	8–21

In the model established in this study, the relationship between neonatal intensive care nurses' AILS and MAI-Readiness was analyzed using structural equation modeling (SEM) in line with the relevant literatüre [16, 20, 23] using SEM. Before testing the research question, the relevant data were included in the Mahalanobis Distance analysis, one of the Multiple Outlier Analyses. As a result of the analysis, five samples were accepted as multiple outliers and excluded from the analysis. Model testing continued with a sample of 195 individuals. In the first stage of SEM, a measurement model was created to test the relationships between the sub-dimensions and latent structures, and the results obtained from the analysis are presented in Table 3.

Table 3
Measurement Model Results*

Construct	Dimension	Unstandardized Loading	Standardized Loadin (β)	p	Alfa (α)	Omega (Ω)	AVE
AILS	Awareness	1.000	0.663	< .001	0.790	0.814	0.537
	Usage	1.395	0.822	< .001			
	Evaluation	1.696	0.849	< .001			
	Ethics	0.910	0.507	< .001			
MAI-Readiness	Cogmitive	1.000	0.842	< .001	0.843	0.903	0.736
	Ability	0.958	0.802	< .001			
	Vision	2.734	0.927	< .001			
	Ethics	2.141	0.784	< .001			
Measurement model fit was acceptable overall:: CFI:0,934; GFI:0,990; AGFI:=0,977; TLI:0,903; NFI: 0,916; x^2 = 81.3, df = 19 x^2/df = 4,27, RMSEA: 0.129, SRMR: 0.049							

*Estimation Method: ML, Optimizastion Method: NLMINB, Iteration: 44

A two-stage approach was adopted in structural equation modeling; in the first stage, the relationships between latent constructs (AILS and MAI-Readiness) and observed variables were tested within the measurement model. As shown in Table 3, all relationships between the relevant dimensions and latent variables are significant ($p < 0.001$). The fit of the measurement model was assessed using various fit indices. The fit indices generally indicate an acceptable fit. In this context, the comparative fit indices CFI (0.934), NFI (0.916), and TLI (0.903) are above the 0.90 threshold value, indicating that the model fits at an acceptable level. The relatively high values of the absolute fit indices GFI (0.990) and AGFI (0.977) reveal that the measurement model exhibits a strong fit with the data [24]. The chi-square statistic is significant (χ^2=81.3; df = 19), and the χ^2/df ratio of 4.27 suggests that the model fit is marginally acceptable. Looking at the error-based fit indices, the SRMR value of 0.049 is below the recommended threshold of 0.08, indicating good fit [25], while the RMSEA value of 0.129 may indicate a need for improvement in the model, particularly in terms of approximate fit. However, Chen et al. [26] stated that RMSEA values below 0.200 are overly conservative in samples. When all fit indices are evaluated together, since the measurement model's fit is acceptable for most indices, the model is considered appropriate, and reliability analyses of the relevant constructs were conducted.

In reliability analyses, both Cronbach's Alpha coefficient and McDonald's Omega coefficient were calculated to obtain the best estimate of the data and to enable a secondary reliability assessment [27]. The findings show that the Cronbach Alpha and McDonald Omega values for both latent structures are above 0.70, indicating that the scales have sufficient internal consistency.

In addition, the Average Explained Variance (AVE) values calculated to assess convergent validity were above the 0.50 threshold, supporting the reliability and convergent validity of the structures. The Average Explained Variance (AVE) values are 0.537 for AILS and 0.736 for MAI-Readiness, both of which are above the 0.50 threshold. This finding indicates that the convergent validity of the scales is established [28].

After model fit and measurement reliability were accepted, structural model analysis was performed and hypotheses were tested as part of the second stage of YEM. Findings related to the structural model are presented in Table 4 and Fig. 1.

Table 4
Structural Model Results

Hypothesis	Relations	Co-efficent (B)	Standard Error (SE)	Standardized Beta (β)	p	R^2	Result
H1	**AILS◊MAI-Readiness**	0.662	0.083	0.757	< .001	0.573	Hypothesis acceptance

The path coefficient (B = 0.662) obtained for the tested H1 hypothesis (AILS → MAI-Readiness) in the structural model analysis was found to be statistically significant (p < .001). This result indicates that a one-unit increase in the AILS level leads to a positive and significant increase of 0.662 units in the MAI-Readiness level. The relatively low standard error value (SE = 0.083) suggests that the coefficient estimate is stable and reliable. Furthermore, it was determined that approximately 57.3% of the variance in the MAI-Readiness variable (R^2 = 0.573) was explained by the AILS variable. This finding indicates that AILS has a strong effect on MAI-Readiness. Based on the results obtained, H1 hypothesis was supported.

DISCUSSION

This study makes a significant contribution to the literature by examining the impact of AI literacy on AI readiness among nurses working in NICUs in Turkey. AI technologies applied in healthcare are increasingly demonstrating promising outcomes in critical aspects of neonatal nursing, including monitoring nutrition, managing pain, and assessing skin integrity and comfort levels [1, 20, 29]. However, the effective and safe integration of this potential into care processes depends on strengthening NICU nurses' AI literacy and supporting their readiness to implement AI applications in practice.

NICUs are high-acuity care environments where premature or clinically unstable term infants are continuously and closely monitored, multiple invasive procedures are frequently performed, and clinical decisions must be made with high accuracy, leaving minimal margin for error [16, 30]. The accelerated integration of AI technologies in healthcare in recent years has led to significant transformations in nursing practice [31]. To effectively capitalize on the potential of AI for enhancing care quality and optimizing healthcare efficiency, nurses must attain a robust level of medical AI readiness. This is

characterized by the capacity to critically interpret AI-generated outputs, seamlessly integrate them into clinical workflows, and foster active collaboration with AI systems practice [14, 32]. In the present study, the mean MAI-Readiness score was 70.21 ± 17.53, indicating that participants generally demonstrated familiarity with and a relatively positive acceptance of this technology. Similarly, Çevik Aktura and Dertli found that mean MAI-Readiness scores of 67.17 ± 18.19 among nurses and 69.41 ± 15.18 among students, suggesting a moderate-to-high level of AI readiness in the literatüre [31]. These findings gain further significance when interpreted within the framework of the Technology Acceptance Model (TAM). According to TAM, an individual's intention to adopt a new technology is primarily determined by perceived usefulness and perceived ease of use. In technology-intensive environments such as Neonatal Intensive Care Units (NICUs), nurses may more clearly discern the contributions of AI systems to clinical decision-making, thereby enhancing their perceived usefulness. However, for this perception to be sustainably strengthened, a knowledge-based literacy foundation is essential [33]. Consequently, while neonatal nurses appear to possess a positive baseline disposition toward AI technologies, these results suggest that literacy-based strategies are imperative to ensure their sustainable and safe integration into clinical practice.

Increasing AI literacy may empower nurses to critically appraise AI-driven tools regarding their safety, inherent biases, and clinical utility. Such competencies are instrumental in safeguarding patient outcomes and upholding ethical standards within increasingly digitalized healthcare environments [11, 34]. In the present study, the mean total score on the AILS among NICU nurses was 60.29 ± 10.96. In studies conducted with perioperative nurses, it is reported that have reported medium [35] to high [36] levels of AI literacy. This difference may be related to the more intensive and routine use of technological tools in surgical settings. The literature emphasizes that individuals who understand and can analyze technological advancements tend to demonstrate higher levels of AI literacy [37, 38]. In this context, AI literacy encompasses not only technical knowledge but also critical appraisal skills, ethical awareness, and the capacity for clinical integration. Enhancing nurses’ AI literacy represents a crucial step in the digital transformation of healthcare. Supported by continuous skill development and guidance in ethical practice, this literacy enables nurses to act confidently and safely within technologically advanced care environments.

Nurses who effectively utilize AI and possess strong AI literacy skills are able to guide and empower patients, potentially contributing to improved health outcomes [39]. Coşkun et al. reported that neonatal nurses perceive AI as a tool that standardizes routine procedures, such as skin assessments, optimizing workflow and allowing nurses to allocate more time to complex clinical tasks [20]. NICUs are high-technology clinical environments, where AI-supported monitoring, clinical risk prediction algorithms, and decision support systems are increasingly utilized. According to the TAM, nurses with low AI literacy may experience increased perceptions of algorithmic uncertainty, loss of control, and professional threat, which can diminish perceived usefulness and foster resistance [33]. In contrast, nurses with higher AI literacy demonstrate greater confidence, critically evaluate system outputs, and exhibit stronger readiness for technological integration. Findings from the structural model analysis in the present study provide strong support for the primary hypothesis (H1). The results indicate that AILS has a statistically

significant and positive effect on MAI-Readiness. This finding demonstrates that as neonatal nurses' AI literacy increases, their readiness to adopt these technologies in clinical practice correspondingly improves. The observed strong effect of AILS on MAI-Readiness is consistent with previous adaptation studies of similar AI tools and underscores the importance of knowledge accumulation in shaping healthcare professionals' application of AI in practice [5, 9, 36].

The strong path coefficient observed between AILS and MAI-Readiness in this study indicates that AI literacy is not merely a repository of knowledge, but a key determinant of trust in AI during clinical decision-making. The use of AI represents a significant opportunity to enhance the quality of care in NICUs. However, the literature suggests that nurses' utilization of AI remains insufficient [14, 34, 35]. In this context, improving AI literacy can strengthen nurses' ability to critically evaluate AI tools in terms of safety, bias, and clinical appropriateness [40]. Such competencies contribute to patient safety and support the maintenance of ethical practices in increasingly digitalized care environments. In high-stakes settings such as NICUs, where tolerance for error is minimal, perceiving AI as a tool that supports rather than threatens care is achievable only through a well-developed literacy foundation.

CONCLUSION

This study empirically demonstrates the pivotal role of AI literacy in shaping AI readiness among nurses working in NICUs in Turkey. Structural equation modeling results confirmed a significant and positive relationship between AILS and MAI-Readiness. The findings indicate that as nurses' literacy levels increase, their perceived self-efficacy and willingness to integrate AI technologies into clinical decision-making processes also improve. Consequently, the safe, ethical, and sustainable adoption of AI in critical care areas such as NICUs is achievable not solely through technological infrastructure investments, but primarily through the enhancement of healthcare professionals' cognitive and technical competencies.

These results suggest that in high-risk, low-error-tolerance environments like NICUs, AI integration represents a cognitive transformation process rather than a purely technical adaptation. The safe, ethical, and sustainable adoption of AI by neonatal nurses depends not only on strengthening algorithmic systems but also on developing professionals capable of critically evaluating AI outputs and adapting them to the clinical context.

Accordingly, enhancing AI readiness among neonatal nurses fundamentally requires strengthening their AI literacy skills. For future planning, integrating AI-focused content, awareness, and digital ethics modules into undergraduate and graduate nursing curricula should be considered essential. Furthermore, structured, evidence-based in-service training programs in clinical settings are likely to foster an institutional culture that supports the safe and effective use of AI in healthcare practice.

Implications to practice

The findings of this study provide a practical strategic roadmap for enhancing AI integration and clinical effectiveness in neonatal nursing. To increase nurses' readiness, the systematic incorporation of AI-

focused courses and AI health literacy modules into undergraduate and graduate nursing curricula may enhance professional development.

At the clinical level, structured in-service training programs tailored to the high-risk nature of NICUs—covering scenarios such as sepsis prediction, pain management, and skin assessment—can be implemented. These programs facilitate the translation of theoretical knowledge into practical skills, reducing medical errors and promoting more effective use of clinical decision support systems. Moreover, standardized training protocols addressing AI ethics and data security can help overcome resistance among nurses during technological transformation, thereby optimizing care quality.

Limitations and strengths

This study has several notable strengths. Despite the rapid integration of AI technologies into daily life and healthcare, it provides valuable empirical data on the readiness and literacy levels of nurses working in NICUs. The data collection process was conducted meticulously using well-structured questionnaires, and structural equation modeling yielded robust findings.

However, this study has some limitations. Data were collected online, which may introduce self-selection bias. Additionally, the limited number of studies in the literature focusing specifically on neonatal intensive care nurses restricts opportunities for direct comparison and contextualization of the findings.

Abbreviations

AI
Artificial Intelligence
AILS
Artificial Intelligence Literacy Scale
AVE
Average Variance Extracted
CR
Composite Reliability
HTMT
Heterotrait–Monotrait Ratio
MAI-readiness
Medical Artificial Intelligence Readiness Scale
NICUs
Neonatal Intensive Care Units
SEM
Structural Equation Modeling
STROBE
Strengthening The Reporting Of Observational Studies in Epidemiology

Declarations

Ethics Statement and Consent to Participate

Ethical approval

for the study was obtained from the Non-Interventional Clinical Research Ethics Committee of a Bandırma Onyedi Eylul University (Approval Date: June 27, 2025; Decision No: 2025-06). Informed consent forms were obtained from neonatal nurses who were informed about the purpose and scope of the research and who wanted to participate in the study voluntarily. Access to the survey questions was provided if the nurses approved the consent box. The permission of the authors of the scales to be used in the study was obtained. The study was conducted in accordance with the principles of the Declaration of Helsinki.

Consent for publication

Not applicable.

Conflicts of Interest

The authors declare no conflicts of interest.

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Author Contribution

Zübeyde Ezgi ERÇELİK: Writing – original draft, Conceptualization, Writing – review & editing. Diler YILMAZ : Supervision, Writing – review & editing, Software, Methodology, Conceptualization. Merve Nur ERYILMAZ TAŞ: Investigation, Data curation, Methodology.

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Data Availability

The data supporting the study's findings are available from the corresponding author upon reasonable request.

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Figures

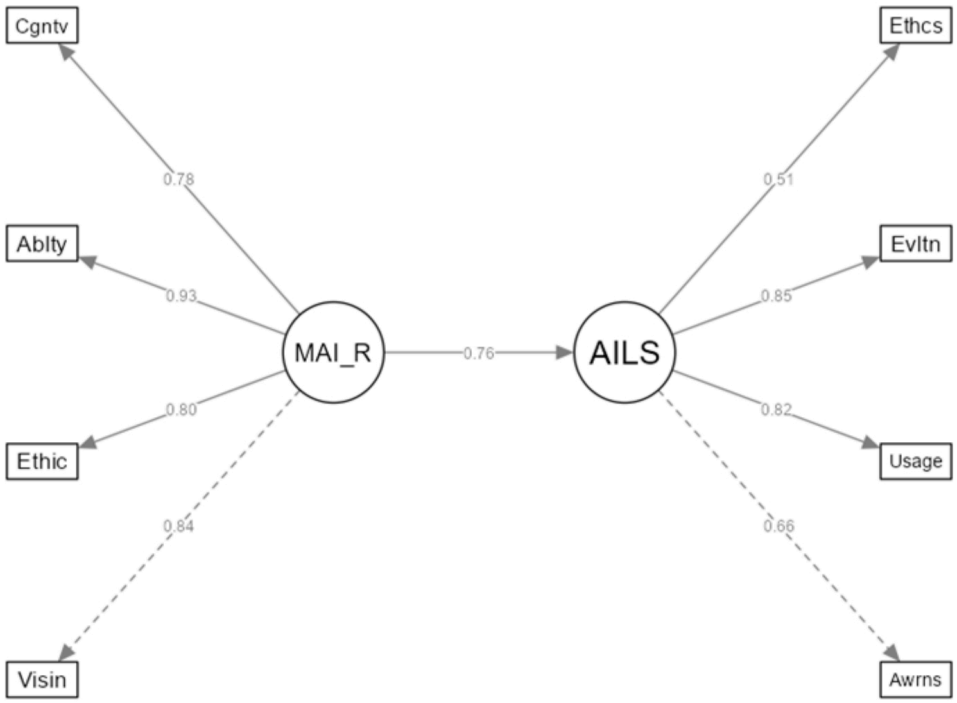

Figure 1

Structural Equation Model Diagram (the Relationship Between Artificial İntelligence Literacy Levels and Medical AI Readiness)