LICENSED NURSES’ PERCEPTIONS OF ETHICAL CLIMATES IN SKILLED NURSING FACILITIES

Anna A Filipova

Key words: ethical climate types; licensed nurses; value incongruence

This study examines the presence of ethical climates in skilled nursing facilities and identifies their antecedents (work group, job position, tenure). A cross-sectional survey design was implemented. A total of 359 facilities were selected in the Midwestern United States. Responses were received from nurses representing 100 of those facilities (28%). A total of 656 usable questionnaires were returned of the 3060 distributed (21.4% response rate). Descriptive statistics, confirmatory factor analysis, and multivariate and univariate analyses of variance were used. The results confirmed the presence of five ethical climates. Significant differences between registered and licensed practical nurses with regard to egoistic and independence ethical climates were found. Furthermore, nurses in management and non-management positions differed significantly in their perceptions of caring and egoistic climates. The results suggest incongruence in value perceptions and imply that researchers and practitioners have to direct efforts towards preventing and identifying reasons behind this.

Introduction

Ethical issues inherent in nursing practice are a major topic of discussion in the nursing literature. This also reflects increasing public concern about the quality of services provided in nursing homes. In skilled nursing facilities, quality of life issues are addressed 24 hours a day and 7 days a week. Ethical conduct during this long course of care is important because it affects the well-being of the residents. Nursing decisions must be construed in an ethical context and high staff morale is essential to maintaining a staff willing to be productive, committed to quality, and able to handle ethical issues within their daily work activities. Given that ethical climate has been associated with ethical behavior, developing knowledge about ethical climates in skilled nursing facilities takes on a critical role. The purpose of this study is to fill a gap in the nursing literature by establishing the presence of ethical climate types and identifying antecedents (work group, job position, tenure) that may produce them.

Address for correspondence: Anna A Filipova, University of Wisconsin-Oshkosh, Public Affairs Department, 800 Algoma Blvd, Oshkosh, WI 54901, USA. E-mail: afilipova@hotmail.com

Nursing Ethics 2009 16 (5) © The Author(s), 2009. 10.1177/0969733009106650
Reprints and permissions: http://www.sagepub.co.uk/journalsPermissions.nav
Background and significance of the study

The Joint Commission on Accreditation of Health Care Organizations and the United States Sentencing Commission have introduced standards and compliance initiatives to ensure integrity of ethical decision making and ethical sensitivity throughout health care institutions. The American Nurses Association has also developed guidelines for nurses’ participation and leadership in ethical decision making. Although these measures aim at eliminating unethical practices and controlling unethical behavior, reliance on external constraints ignores the impact of the organizational environment on the ethical behavior of its individual members. How nurses and others perceive their work setting can affect their attitudes about ethical issues and their roles in making ethical decisions. By using a measure of ethical climate, researchers can understand the ethics within organizations and nurses’ ethical practices and behaviors.

Organizational values define what the members of an organization care about and are used as standards for making moral judgments. Those values that pertain to ethical issues and identify what is ethically correct contribute to an ethical climate in the organization. Thus, ‘the shared perceptions of what is ethically correct behavior and how ethical issues should be handled both reflect and define the ethics of an organization.’ (pp. 51–52). The importance of creating and improving an ethical climate has been underscored in the nursing literature. Hospital studies have addressed issues related to nurses’ ethical stress, job satisfaction, and turnover intentions. For example, Joseph and Deshpande found that nurses who believed their hospital had caring and rules climates were more satisfied with their pay and supervisors. Hart provided evidence that a negative ethical climate was associated with registered nurses’ decision to leave their job or the nursing profession. Similarly, Ulrich and colleagues established that a positive ethical climate reduced nurses’ intentions to leave. However, Schluter and colleagues’ review of ethical climate research in nursing literature revealed that the construct and its consequences still remained ‘underinvestigated’ and lacked ‘methodological rigor’ (p. 318).

Although a number of investigators have studied ethical climates in hospital settings, less focus has been directed towards the environment in skilled nursing facilities. Coward et al. suggested that findings from studies in hospital settings could not be generalized to nurses working in nursing homes. As a consequence, there is a gap in the literature about the types of ethical climates and their antecedents and consequences, as well as actions that can be taken by administrators to influence the ethical environment. Because ethical subclimates might provide a more accurate way to evaluate the work climate, their identification could allow controlling ethical behavior in organizations.

This article begins with a discussion of theory and empirical research on ethical climates, and antecedents and specific hypotheses are developed. The method section is followed by the findings of the study. The results are then discussed together with their implications for researchers and practitioners. Finally, study limitations are noted and suggestions for future research proposed.
Literature review

Ethical climates

Victor and Cullen\textsuperscript{13,25} hypothesized the presence of various ethical climate types, based on two dimensions:

1) Ethical criteria: egoism, benevolence (utilitarianism), or principlism (deontology) used to make decisions;
2) The ‘locus of analysis’: individual, local (work group) or cosmopolitan (societal or global).

These two dimensions combine in unique ways for different organizations; that is, different criteria for moral judgment (egoistic, benevolent or principle) and different loci of analysis (individual, local or cosmopolitan). After empirical examination, the nine theoretically possible ethical climates in Victor and Cullen’s three-by-three matrix were reduced to five that actually occurred: instrumental, caring, independence, rules, and laws and codes. The following descriptors briefly define those climates.

1) Instrumental: ‘In this organization, people protect their own interest above all else.’
2) Caring: ‘In this organization, people look out for each other’s good.’
3) Independence: ‘In this organization, people are expected to follow their own personal moral and ethical beliefs.’
4) Rules: ‘In this organization, everyone is expected to stick by organization rules and procedures.’
5) Law and Code: ‘In this organization, the first consideration is whether a decision violates any law’ (p. 112).\textsuperscript{25}

Martin and Cullen’s\textsuperscript{26} meta-analysis of ethics climate research reveals that the five ethical climate types had been validated in many prior exploratory studies. However, few studies,\textsuperscript{15,27} which also employed small samples, had confirmed their presence in health care settings. In the present study, the following hypothesis was proposed:

Hypothesis 1: The ethical climate types identified by Victor and Cullen\textsuperscript{13,25} will be confirmed to exist in skilled nursing facilities.

Antecedents of ethical climates

Van Maanen and Barley\textsuperscript{27} provide two explanations for the formation of subcultures. First is the interpersonal attraction hypothesis, which suggests that similar people will be attracted to an occupation, a job, a position in the hierarchy, or a particular organization because they have common perceptions and/or similar attitudes. A second explanation for subculture differentiation involves interpersonal interaction among organizational members. When individuals interact often, groups are more likely to form and become cohesive.\textsuperscript{12} Task interdependence, reporting relationships, proximity, design of offices, and shared equipment or facilities all bring certain members of an organization into contact with one another and could be regarded as possible contributors to the formation of subcultures.\textsuperscript{12}

Victor and Cullen\textsuperscript{25} state that a major determinant of ethical climate can be the unique characteristics of organizations’ histories and individuals’ histories in the organization.
Consistent with Van Maanen and Barley’s interpersonal attraction postulation, Victor and Cullen point out that individuals may hold similar ethical climate perceptions even if they do not interact because of similar organizational positions such as job function. Empirical ethical climate research\textsuperscript{24,25} has established that ethical climate perceptions vary across subunits, jobs and tenure levels, suggesting that the predominant ethical climate type may be located in a particular work group without actually being shared throughout the organization. To the extent that different subgroups within organizations have identifiably different climates, such climates likely indicate the existence of organizational subcultures.\textsuperscript{25}

Using a convenience sample of 360 registered nurses in two acute-care hospitals, Olson\textsuperscript{2} established that hospital nurses experienced subclimates through their perceptions of organizational conditions and practices dealing with the discussion and resolution of patient care problems with ethical implications. They were organized according to nurses' perceptions of interactions with peers, patients, managers, the hospital and physicians. Findings showed that the five climate dimensions were highly intercorrelated and could not be considered independent.

In line with the above discussion, an assumption was that the predominant dimension of ethical climate could be located in particular work groups, but not necessarily shared by others within an organization. Howe (cited by Victor and Cullen (p. 108))\textsuperscript{25} suggested three types of aggregation for evidence of climate: person variables (e.g. age and sex), situation (e.g. work group, job level) and person-situation variables (e.g. tenure and salary). In keeping with these criteria, both situation variables based on \textit{a priori} distinctions between level of qualification (registered nurses and licensed practical nurses) and job position (director of nursing, administrative nurse, charge nurse, staff nurse, other), and a joint person-situation variable based on distinctions between years in the facility were considered.

For the current study, it was predicted that the rating scores for ethical climate perceptions would differ among licensed nurses by level of qualification, job position, and years in the facility. The following hypotheses were tested:

Hypothesis 2: There is an overall difference in licensed nurses’ perceptions of ethical climates by level of qualification.

Hypothesis 3: There is an overall difference in licensed nurses’ perceptions of ethical climates by job position.

Hypothesis 4: There is an overall difference in licensed nurses’ perceptions of ethical climates by years in the facility.

\section*{Method}

\section*{Design and procedure}

A cross-sectional design was used to survey registered and licensed nurses in one Midwestern state. Facilities that had at least 50 beds and were free standing were considered eligible for the study. The final sample consisted of 359 facilities, the administrators of which agreed to participate by providing a list of nurses employed for 35 hours per week or more on all shifts, and all nurses within participating facilities that agreed voluntarily to participate. Permission to conduct the study was obtained from the Human Subjects Institutional Review Board of Western Michigan University.
Facility recruitment occurred in four stages:

1) Formal letters, using first class postage, were mailed to 359 administrators. The letters explained the purpose of the study and the data collection procedures, also assuring complete confidentiality of nurses’ responses, and that the facility and the state would not be identified. Each letter was personally signed.

2) Owing to the low response rate of 10% and the unwillingness of some administrators to provide nurses’ names, a reminder letter was sent. In addition to requesting nurses’ names, two additional options were: (a) to provide the number of nurses and agree to distribute surveys to the nurses; and (b) to state if the facility was not able to participate in the study. As a result, the response rate increased to 24%.

3) After the final reminder letter, the response rate rose to 31%.

4) To increase awareness about the upcoming surveys, thank-you letters were sent to administrators who agreed to participate. Administrators who declined participation also received thank-you letters and no further action was taken.

The survey data were collected from September through December 2006. A total of 3060 survey packets were sent either to the administrator or a designated person for distribution, using priority mailing, or directly to the individuals using first-class postage. A survey packet included a cover letter that was personally signed, explaining the survey and assuring confidentiality, a survey booklet, and a postage-paid business-reply envelope addressed to the investigator’s university.

Reminder cards were eventually submitted to administrators of 10 non-responding facilities asking them to remind nurses that they could volunteer to participate. Since no surveys were received from these facilities, they were not counted in the study. The final number of participating facilities was 100 (27.9% of the total). A total of 728 surveys of the 3060 distributed were returned. After listwise deletion of missing values, the investigator was left with a sample of 656 respondents (21.4% response rate).

Demographics

The sample consisted primarily of women (94%). The respondents’ age ranged from less than 25 to more than 54 years, with nearly 37% falling between 44 and 53 years. There was a fairly equal representation of registered nurses (45%) and licensed practical nurses (55%). More than half of the licensed nurses had worked in the facility for between 5 and 9 years (23%) or for more than 10 years (29%). The two largest groups by job position were staff nurses (37%) and charge nurses (35%); 28% were from other positions: administrative nurses (19%), directors of nursing (5%), and others (4%). Participation by facility ownership type was: 40% for profit, 33% not for profit, and 27% government.

Operationalization of ethical climate

Data on ethical climates were collected via the 26-item Ethical Climate Questionnaire, with additional questions concerning demographic and employment characteristics. As suggested by Victor and Cullen, the nurses were asked to respond to questions in terms of how the climate of their organization actually was and not how they would like it to be. Items were measured on a 6-point Likert scale (1 = completely false;
6 = completely true). The alpha coefficient for ethical climate types ranged from 0.60 to 0.85.\textsuperscript{13,25}

**Measure assessment**

Both the reliability and validity of the measures were assessed. The climate scales had satisfactory reliabilities well above a Cronbach’s alpha coefficient value of 0.70,\textsuperscript{28} with the exception of low reliability of the independence scale (\(\alpha = 0.61\)). Convergent validity was examined by confirmatory factor analysis using AMOS 6.0. Confirmatory factor analysis is a way of testing how well measured variables represent a small number of constructs.\textsuperscript{28} The average percentage of variance extracted, a summary indicator of convergence, fell between 0.50 and 0.86, satisfying the 50% rule of thumb for adequate convergence.\textsuperscript{28}

**Results**

**Ethical climate types**

Victor and Cullen’s\textsuperscript{13,25} measurement models were evaluated for best fit to the present data in terms of the number of climate types and the items representing each type. Evidence of good fit would include a combination of significant chi-square (\(\chi^2\)) values, a goodness-of-fit index close to 1.00, a standardized root mean residual of 0.08 or lower (with a comparative fit index above 0.92), and a root mean square error of approximation of less than 0.07 (with a comparative fit index of 0.90 or higher).\textsuperscript{28} As shown in Table 1, confirmatory factor analysis revealed that neither of Victor and Cullen’s two models, consisting of six and five ethical climate types respectively, provided a reasonably good fit for the data.

Diagnostics suggested that a better fit might be obtained by removing eight items that had either standardized loadings below the minimum requirement of 0.50 (items 6, 7, 8, 9, 19) or exhibited standardized residuals greater than 14.0 (items 2, 14, 22)\textsuperscript{28} (Table 2). The efficiency climate items 6, 7 and 14 did not load high either on the efficiency factor or the caring factor. This finding was consistent with previous published research.\textsuperscript{29}

The final model consisting of five climate types (professionalism, caring, instrumental, rules and independence) was the closest to satisfying the requirements for a good fit, with a \(\chi^2\) value of 459.186 (125 degrees of freedom, \(P = 0.000\)), a goodness-of-fit index of 0.925, a root mean square error of approximation of 0.064, a standardized root mean residual of 0.049, and a comparative fit index of 0.935 (Table 1). There were no problematic errors and all item loadings were at or above the minimum requirement of 0.50, except for item 20, retained for model identification purposes.\textsuperscript{28}

Most of the respondents identified the presence of a professionalism climate (mean = 4.79, standard deviation (SD) = 0.90). This was followed by a rules climate (mean = 4.27, SD = 0.98), a caring climate (mean = 3.60, SD = 1.21), an independence climate (mean = 3.57, SD = 1.06), and an instrumental climate (mean = 3.15, SD = 1.22).

**Additional hypotheses testing**

Using STATA 8.2, a multivariate analysis of variance (MANOVA) was conducted to determine if there were differences in the mean responses on ethical climate types.
The ethical climate scales were used as the dependent variables in the MANOVA. Hypothesis 2 was tested to determine if registered nurses and licensed practical nurses described distinct ethical climates. In the analysis by level of qualification (Table 3), a significant overall difference was detected (MANOVA $F = 2.32$, $P = 0.04$), thus supporting the hypothesis. Specifically, univariate analyses of variance (ANOVA) revealed that differences found between the groups were significant only for the instrumental ethical climate (ANOVA $F (1654) = 4.22$; $P = 0.04$) and the independence ethical climate (ANOVA $F (1654) = 4.53$; $P = 0.03$).

The ANOVA results showed licensed practical nurses, on average, as perceiving a more instrumental climate (mean = 3.37) than registered nurses (mean = 3.16) (Table 3). The post hoc test revealed that the difference was significant ($0.21$, $P = 0.04$). On the other hand, licensed practical nurses, on average, were less likely to describe a climate in a facility as independent (mean = 3.49) than registered nurses (mean = 3.67) (Table 3). The post hoc test confirmed a difference of $-0.18$ ($P = 0.03$).

Hypothesis 3, which tested whether nurses who perform different functions identified distinct ethical climates was supported because a significant overall difference was found by job position (MANOVA $F = 2.75$, $P = 0.001$). Specifically, Table 4 shows that the differences between groups were significant only for the caring climate (ANOVA $F (4651) = 7.64$; $P = 0.00$) and instrumental climate (ANOVA $F (4651) = 7.74$; $P = 0.00$).

The ANOVA revealed that charge nurses, on average, perceived a less caring climate (mean = 3.39) than administrative nurses (mean = 3.99) and directors of nursing (mean = 4.15). The post hoc test confirmed significant differences of $-0.60$ ($P = 0.00$).
Table 2  Confirmatory factor analysis results: factor loadings for three climate type models

<table>
<thead>
<tr>
<th>Item</th>
<th>Standardized loading*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Victor and Cullen(^{1a})</td>
</tr>
<tr>
<td></td>
<td>((n = 151))</td>
</tr>
<tr>
<td>1) Consideration for what is best for all employees (BL)</td>
<td>0.77</td>
</tr>
<tr>
<td>2) Concern for what is best for the other person (BI)</td>
<td>0.62</td>
</tr>
<tr>
<td>3) Concern for the good of all people (BL)</td>
<td>0.73</td>
</tr>
<tr>
<td>4) People look out for each other (BI)</td>
<td>0.78</td>
</tr>
<tr>
<td>5) Do what is right for the customer (BC)</td>
<td>0.65</td>
</tr>
<tr>
<td>6) The most efficient way is always the right way (EC)</td>
<td>0.24</td>
</tr>
<tr>
<td>7) Each person is expected to work efficiently (EC)</td>
<td>0.25</td>
</tr>
<tr>
<td>8) Concern only with organization’s interest (EL)</td>
<td>0.19</td>
</tr>
<tr>
<td>9) No room for one’s own personal morals or ethics (EI)</td>
<td>0.49</td>
</tr>
<tr>
<td>10) People are mostly out for themselves (EI)</td>
<td>0.84</td>
</tr>
<tr>
<td>11) People protect their own interest above all else (EI)</td>
<td>0.80</td>
</tr>
<tr>
<td>12) Work is substandard only if it hurts the organization (EL)</td>
<td>0.68</td>
</tr>
<tr>
<td>13) Further organizational interest regardless of consequences (EL)</td>
<td>0.59</td>
</tr>
<tr>
<td>14) Major responsibility of people is to control costs (EC)</td>
<td>0.26</td>
</tr>
<tr>
<td>15) Important to follow rules and procedures (PL)</td>
<td>0.65</td>
</tr>
<tr>
<td>16) Successful people go by the book (PL)</td>
<td>0.72</td>
</tr>
<tr>
<td>17) All expected to stick by organization’s rules (PL)</td>
<td>0.72</td>
</tr>
<tr>
<td>18) People strictly obey organization’s policies (PL)</td>
<td>0.76</td>
</tr>
<tr>
<td>19) Each person decides for themselves what is right (PI)</td>
<td>0.31</td>
</tr>
<tr>
<td>20) People are guided by their own personal ethics (PI)</td>
<td>0.55</td>
</tr>
<tr>
<td>21) People are expected to follow own moral beliefs (PI)</td>
<td>0.78</td>
</tr>
<tr>
<td>22) Consideration is each person’s sense of right (PI)</td>
<td>0.49</td>
</tr>
<tr>
<td>23) People are expected to follow standards strictly (PC)</td>
<td>0.78</td>
</tr>
<tr>
<td>24) People are expected to comply with the law (PC)</td>
<td>0.82</td>
</tr>
<tr>
<td>25) First consideration is if decision violates the law (PC)</td>
<td>0.52</td>
</tr>
<tr>
<td>26) Law is a major consideration (PC)</td>
<td>0.73</td>
</tr>
</tbody>
</table>

* t-values of all standardized loadings in all three models were significant at \(p = 0.001\) (two-tailed).

\(^{1}\)Six ethical climate types: caring (items 1, 2, 3, 4), efficiency (items 6, 7, 14), instrumental (items 8, 9, 10, 11, 12, 13), rules (items 15, 16, 17, 18), independence (items 19, 20, 21, 22), and professionalism (items 5, 23, 24, 25, 26).

\(^{2}\)Five ethical climate types: caring (items 1, 2, 3, 4, 6, 7), instrumental (items 8, 9, 10, 11, 12, 13, 14), rules (items 15, 16, 17, 18), independence (items 19, 20, 21, 22), and law and code (items 23, 24, 25, 26).

\(^{3}\)Five ethical climate types confirmed: caring (items 1, 3, 4), instrumental (items 10, 11, 12, 13), rules (items 15, 16, 17, 18), independence (items 20, 21), and professionalism (items 5, 23, 24, 25, 26).

E, egoism; B, benevolence; P, principle; I, individual; L, local; C, cosmopolitan.

and \(-0.76\) (\(p = 0.001\)) respectively. Similarly, staff nurses, on average, had a lower mean score on caring climate (mean = 3.58) compared with administrative nurses (mean = 3.99). The post hoc test revealed a difference of \(-0.41\) (\(p = 0.02\)).

The ANOVA results also showed that, on average, charge nurses perceived a more instrumental climate (mean = 3.38) than administrative nurses (mean = 2.83) and
Table 3  Results of ANOVA and MANOVA (see footnote) by level of qualification

<table>
<thead>
<tr>
<th>Ethical climate</th>
<th>Univariate results $F$ (1654)</th>
<th>$P$-value</th>
<th>Mean ($n = 656$)</th>
<th>Registered nurses ($n = 298$)</th>
<th>Licensed practical nurses ($n = 358$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring</td>
<td>1.28</td>
<td>0.26</td>
<td>3.66</td>
<td>3.56</td>
<td></td>
</tr>
<tr>
<td>Professionalism</td>
<td>0.18</td>
<td>0.67</td>
<td>4.77</td>
<td>4.80</td>
<td></td>
</tr>
<tr>
<td>Rules</td>
<td>0.04</td>
<td>0.85</td>
<td>4.26</td>
<td>4.28</td>
<td></td>
</tr>
<tr>
<td>Instrumental</td>
<td>4.22</td>
<td>0.04</td>
<td>3.16*</td>
<td>3.37*</td>
<td></td>
</tr>
<tr>
<td>Independence</td>
<td>4.53</td>
<td>0.03</td>
<td>3.67**</td>
<td>3.49**</td>
<td></td>
</tr>
</tbody>
</table>

*P = 0.04; **P = 0.03
MANOVA: Wilk’s lambda = 0.98; $F = 2.32; P = 0.04$

Table 4  Results of ANOVA and MANOVA (see footnote) by job position

<table>
<thead>
<tr>
<th>Variable</th>
<th>Univariate results $F$ (4651)</th>
<th>$P$-value</th>
<th>Mean ($n = 656$)</th>
<th>DON ($n = 31$)</th>
<th>Adm. Nurse ($n = 124$)</th>
<th>Charge Nurse ($n = 228$)</th>
<th>Staff Nurse ($n = 244$)</th>
<th>Other ($n = 29$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring</td>
<td>7.64</td>
<td>0.00</td>
<td>4.15*</td>
<td>3.99*</td>
<td>3.39*</td>
<td>3.58*</td>
<td>3.20*</td>
<td></td>
</tr>
<tr>
<td>Professionalism</td>
<td>2.30</td>
<td>0.06</td>
<td>5.10</td>
<td>4.91</td>
<td>4.77</td>
<td>4.74</td>
<td>4.52</td>
<td></td>
</tr>
<tr>
<td>Rules</td>
<td>2.14</td>
<td>0.07</td>
<td>4.40</td>
<td>4.40</td>
<td>4.30</td>
<td>4.20</td>
<td>3.88</td>
<td></td>
</tr>
<tr>
<td>Instrumental</td>
<td>7.74</td>
<td>0.00</td>
<td>2.70*</td>
<td>2.83*</td>
<td>3.43*</td>
<td>3.38*</td>
<td>3.76*</td>
<td></td>
</tr>
<tr>
<td>Independence</td>
<td>1.97</td>
<td>0.10</td>
<td>3.98</td>
<td>3.67</td>
<td>3.47</td>
<td>3.57</td>
<td>3.53</td>
<td></td>
</tr>
</tbody>
</table>

*P = 0.000
MANOVA: Wilk’s lambda = 0.92; $F = 2.75; P = 0.001$
DON, director of nursing; Adm. Nurse, administrative nurse.

directors of nursing (mean = 2.70). The post hoc test confirmed significant differences of 0.60 ($P = 0.00$) and 0.73 ($P = 0.03$) respectively.

In testing the validity of Hypothesis 4, no significant overall differences were found among nurses in their perceptions of ethical climates based on years in the facility. Hypothesis 4 was therefore not supported.

Discussion

A contribution to knowledge on the perception of ethical climates made by this study is the finding of distinctly identifiable ethical climates in skilled nursing facilities. The results of the confirmatory factor analysis suggested that the fit of Victor and Cullen’s$^{13,25}$ models could be rejected as not providing an adequate fit for the present data. Nevertheless, it would appear reasonable to maintain that Victor and Cullen’s$^{25}$ five-dimensional model provides a good fit after the elimination of certain questionnaire items. Similar to Agarwal and Malloy’s$^{29}$ findings, the items representing the efficiency climate did not constitute a distinct factor. Furthermore, consistent with previous research,$^{13,15}$ the law and code climate was renamed professionalism. In concurrence
with Peterson, the findings also suggest that a confirmatory factor analysis procedure may be the most appropriate one for confirming the validity of hypothesized ethical climate models.

Professionalism was the climate most reported by licensed nurses, followed by rules, caring, independence and instrumental climates. The results were partially consistent with Joseph and Deshpande’s study, in which nurses reported the presence of ethical climates in the following sequence: professionalism, rules, instrumental, caring, independence and efficiency. The significance placed on professionalism and rules climates suggested a strong emphasis on conforming to the highly regulated environment and strict adherence to rules and procedures. The caring climate, in terms of team spirit and peer support, had a relatively lower score than the professionalism climate.

Next, consistent with previous research, the results showed that the unique characteristics of individuals’ histories in organizations could be major determinants of ethical climates. Differences were established in licensed nurses’ ethical climate perceptions by level of qualification and job position. Licensed practical nurses put lower emphasis on the use of personal morality in decision making (independence climate) compared with registered nurses. Furthermore, this work group was more likely than registered nurses to define the climate in the organization as egoistic (i.e. one motivated by self-interest). Similarly, non-management nurses (charge, staff and other) perceived an ethical climate that was less caring and more egoistic than administrative staff. Tuckett also found work practices and a culture in Australian nursing homes that prioritized doing for (instrumental care) over being with (empathic engagement). According to Tuckett, such practices and culture cannot advance the needs and values of residents in high-level care facilities for elderly people.

Several explanations may be possible for these differences in ethical climate perceptions. Licensed practical nurses’ view of a less independent climate may be a result of management’s practices to resolve ethical issues by relying on their own personal standards and values in isolation from staff input. Berger et al. point out that reliance on personal values to clarify ethical issues, policies and codes without consultation with nursing colleagues may not be the best approach in deciding professional practice issues and could enhance the stress of decision making. It would also make it difficult for non-management staff to take policies and codes seriously or to apply them usefully.

According to organizational support theory, employees form a general perception concerning the extent to which the organization values their contributions and cares about their well-being. Because a caring ethical climate is synonymous with general caring for the well-being of employees, it can make employees feel a higher level of organizational support. In this study, non-management nurses perceived a less caring climate, which could be a result of lack of organizational support and respect. Laschinger et al. found that feeling respected by their supervisors was strongly related to nurses’ positive perceptions of organizational support. This finding was similar to that of Laschinger, who noted that respect was a very important predictor of staff nurses’ trust in management and job satisfaction. Respect was also demonstrated through the fair distribution of resources, time to deal effectively with work-related issues, and supervisory support to manage the heavy workloads associated with current roles and expectations. When such actions are missing within an organization they may signal to nurses that the organization cares less about its employees.
A possible explanation of more egoistic perceptions on the part of licensed practical nurses non-management staff may also stem from intergroup competition. According to Sandel and Johnson,\textsuperscript{35} intergroup competition and conflict are a common phenomenon in skilled nursing facilities. Competition among departments, disciplines, floors or units may sometimes be channeled into forms of expression that promote cohesion among subgroup members, and actually contribute to patients’ treatment. More often, however, such intergroup rivalry serves to undermine morale in staff subgroups, and can be detrimental to patient care.\textsuperscript{33} For example, in some for-profit skilled nursing facilities, staff nurses may be unlikely to seek support in situations of an ethical nature from managers because they may perceive those individuals to be opposed to views that endanger organizational self-interest such as cost control and pursuit of profit. Similarly, nurse managers who act in their own best interest may be perceived as having a Machiavellian orientation; that is, using whatever tactic they feel will help them maintain power and pursue their personal (and organizational) goals.

**Application**

The finding of distinct ethical climates in skilled nursing facilities has implications for both understanding as well as controlling ethical behavior in organizations.\textsuperscript{13} Professionalism was the most reported climate by nurses. A professional climate makes it necessary for nurses to look at the laws, policies and practices of the profession to determine appropriate behavior. However, some organizations may put higher emphasis on the caring or independence climate orientations. Victor and Cullen\textsuperscript{13} suggest that organizations with such orientations may be more prone to resort to violations of laws than those with a predominantly professional climate.

In a study of mid-level managers in non-profit and public organizations in the health and social services sector, Rasmussen \textit{et al.}\textsuperscript{36} found that non-profit managers effected the illusion of compliance in order to benefit their clients. Similarly, when faced with an ethical dilemma of falsifying documents or negatively affecting the people in the organization, a manager from a caring climate may judge that he or she is expected to falsify to help people who work for the organization, even though it is illegal.\textsuperscript{13} In this case, management behavior can be directed by existing organizational norms that conflict with the law. Recent research\textsuperscript{30,37} showed that care providers might risk contravening nurses’ codes of ethics.

A strategy to strengthen awareness and compliance with legal, ethical and professional standards is to engage nurses in ethics dialogue about organization policies, procedures and codes of ethics.\textsuperscript{15,37} Equally important is to monitor the ethical judgment of managers.\textsuperscript{13}

In the present study, registered nurses put higher emphasis on the use of personal morality (independence climate) in decision making than licensed practical nurses. One strategy for achieving a balance between using personal values and professional resources to solve ethical issues is the development of institutional ethics committees.\textsuperscript{1,8,38} Hogstel and Walker\textsuperscript{38} found that only 29\% of long-term care facilities in one county in a Southwestern state had an organized ethics committee. Such committees are necessary to provide consultation services and education for licensed nurses.\textsuperscript{38} The existence of an institutional ethics committee may also prevent unilateral decisions affecting patient care that do not include licensed practical nurses’ input. By providing

\textit{Nursing Ethics} 2009 16 (5)
a forum for the open discussion of ethical issues, institutional ethics committees would allow both registered nurses and licensed practical nurses to take a more proactive role in resolving ethical dilemmas.

Conducting training programs in ethics may be important strategies to reduce non-management nurses’ perceptions of an egoistic climate. Recent research by Grady and colleagues\(^39\) showed that ethics education had a significant positive influence on moral confidence, moral action and the use of ethics resources by nurses \((n = 3000)\). These findings suggest that ethics education may be advantageous in cultivating an ethical environment. Emphasizing discourse ethics,\(^37\) performing ethics audits and using moral character as a selection and promotion criterion,\(^15\) and encouraging ethical behavior by example on the part of leaders\(^17\) are further strategies to increase moral consciousness.

If lack of organizational support and respect is likely to explain the differences in caring climate perceptions, efforts should focus on building team interest or benevolent climates. One strategy to strengthen perceptions of team and organizational support is the implementation of training programs that focus on utilitarian reasoning.\(^15\) According to Sikma,\(^10\) organizational well-being for nursing homes requires formal and informal leaders who can create supportive organizational conditions, engage in caring interventions with staff, and inspire the synergy of caring.

Team-building strategies have been found to be important in enhancing perceptions of a caring climate, for example: joint participation in decision making on the allocation of resources, scheduling, personnel policies, patient treatment, and other issues with ethical implications;\(^38\) fostering levels of mutual trust, confidence and non-evaluative communication; and clarifying nurses’ prescribed and discretionary roles.\(^40\) Such strategies have been noted to enable nurses to feel empowered participants in resolving ethical dilemmas\(^10\) and to reduce competition among them.\(^38\) Moreover, recent studies in nursing homes have shown that various forms of empowerment enhanced perceptions of organizational support and role satisfaction,\(^41\) as well as affective commitment\(^42\) of licensed nursing personnel.

Deutschman\(^43\) points out that each organization must be sensitized to its own problems. It is important that nursing home leaders use surveys to identify climate perceptions by subgroups in order to control or strengthen behaviors that are consistent with that climate.\(^13\) For example, training nurse managers in utilitarian reasoning may be better suited to a caring climate where employees have a sincere interest in the well-being of others in the organization.\(^13,15\) In a professional climate, training may focus on how to integrate ethical decision making into various policies and practices (e.g., performance measurement, promotion and disciplinary actions) or on communicating extensive written codes of ethics to promote high ethical standards.\(^13,15\) Equally important is to conduct evaluation research on the effectiveness of the implemented strategies.\(^5\)

The proposed strategies are summarized as follows:

- To control egoistic behavior, institute ethics education, emphasize ethics discourse, perform ethics audits, use moral character as a selection and promotion criterion, and encourage ethical behavior by example on the part of leaders.
- To strengthen professional behavior, engage nurses in a dialogue about organization policies and codes of ethics, and monitor the ethical judgment of managers.
- To strengthen a caring behavior, institute training programs that focus on utilitarian reasoning and implement various team-building strategies.
• To control independence behavior and implement institutional ethics committees.
• To ensure that strategies are appropriate, and institute ethical climate surveys to identify the predominant climate(s) by various subgroups or units.
• Conduct regular evaluation research to ensure that selected strategies have been effective.

Limitations
The method employed in this ethical climates assessment had certain limitations.
In spite of an intense recruitment effort, the low facility response rate (28%) ascertains Chambers’ view of the difficulty in gathering information in long-term care facilities. Some reasons for non-participation, provided voluntarily by administrators, included ‘not allowed to provide the names of nurses’, ‘studies currently being conducted by other universities’, ‘the facility is closed’, ‘got burned as a result of a study’, and ‘we survey our nurses often’.

The survey response rate (21.4%) was also low compared with other studies. For example, Asch et al. reported an average response rate of 61% for a nursing population based on an analysis of 24 studies that used a mailed survey. Although Dillman’s strategies were considered, follow-up surveys were not submitted for two reasons: (1) anonymity prevented the researcher from tracking non-respondents; and (2) nurses were asked to return blank questionnaires in the enclosed pre-paid business reply envelope if they did not volunteer to participate. Asch et al. acknowledged that surveys that are anonymous and sensitive in nature are ‘more prone to non-response’ (p. 1134).

As with any voluntary data collection effort, it is uncertain whether the data provided by participating licensed nurses were comparable with non-participants. Few nurses volunteered information about their reasons for non-participation (e.g. ‘recently employed in the facility’, ‘hesitant to participate because of retaliation from management’), making it difficult to identify the full characteristics of non-respondents. However, Asch et al. found that even ‘surveys with a high response rate may not provide a representative sample’ (p. 1135). It should be noted that this study used a homogeneous population and a response rate bias may therefore be unlikely.

Given the size of the sample (n = 656) and the wide range of experiences related to being a nurse that may be specific to particular geographic areas, institutions and specialties, more empirical research is needed to confirm the current findings.

Conclusion
An important conclusion of the present study is that distinct ethical climate types do exist in skilled nursing facilities. Moreover, distinct climates were identified at group level. Understanding the antecedents of ethical climates should prompt the design of intervention strategies to change, control or strengthen ethical behavior and climate perceptions. Evaluation research on implemented strategies is also necessary to both enhance understanding of ethics in skilled nursing facilities and aid administrators in the prediction and control of nurses’ unethical behavior. Future studies could also examine ethical climates at subunit level (e.g. rehabilitation, Alzheimer’s care).
to determine where within organizations different climates exist. Finally, research needs to be carried out to establish the impact of distinct ethical climates on ethical behaviors.

Acknowledgements

This research was supported by a Student Award Program grant from the Blue Cross and Blue Shield of Michigan Foundation.

Conflict of interest statement

The author declares that there is no conflict of interest.

Anna A Filipova, Western Michigan University, Kalamazoo, MI, USA.

References

2 Olson L. Hospital nurses’ perceptions of the ethical climate of their work setting. J Nurs Scholarsh 1998; 30: 345–49.