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Nurses' perceptions of ethical climate, work environment, and quality of care in the UAE

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Abstract

The ethical climate and work environment in healthcare are vital factors influencing nursing practice and patient care quality. Although widely studied internationally, little research has explored how these factors interact to affect nursing care quality in the United Arab Emirates (UAE), a region with a diverse workforce and evolving healthcare system. This study aimed to explore registered nurses' perceptions of the ethical climate and its relationship to the quality of nursing care, and to examine how these perceptions are influenced by key characteristics of the work environment within the healthcare context of the UAE. A quantitative correlational study was conducted using survey data collected from 396 registered nurses. Validated instruments, including the Practice Environment Scale of the Nursing Work Index, the Revised Ethical Climate Questionnaire, and the Nursing Quality of Care scale, were used to assess the work environment, ethical climate, and quality of care. Descriptive and inferential statistical analyses, including Pearson correlation and analysis of variance, were performed to examine the relationships among the study variables. Descriptive analysis indicated a generally favorable perception of the work environment and nursing care quality, while the ethical climate was perceived as moderate. Significant positive correlations were found between the nursing work environment and ethical climate, particularly in the principled, benevolent, and egoism dimensions. Additionally, the ethical climate was positively associated with perceived quality of care. A positive nursing work environment combined with a supportive ethical climate is associated with higher perceptions of care quality. Promoting ethical leadership, fostering collaborative team dynamics, and ensuring adequate staffing are essential for improving nurse well-being and patient outcomes. Based on the study findings, healthcare organizations should prioritize structured ethics training, supportive leadership, and safe staffing ratios to strengthen the ethical climate and enhance quality of care. Creating psychologically safe, non-punitive systems and fostering nurse participation in decision-making can further improve ethical perceptions. Tailored support for clinical nurse specialists is also essential, given their complex roles.

Keywords: Ethical climate, Healthcare settings, Nursing work environment, Quality of care, Registered nurses.

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1. Introduction

The quality of nursing care is influenced not only by clinical competence and technical skills but also by the ethical and organizational environment in which nurses operate [1, 2]. The ethical climate within healthcare settings plays a pivotal role in shaping nurses' professional behaviors and the overall quality of patient care. It encompasses the shared perceptions among staff regarding ethical standards and the management of ethical issues, forming a foundational aspect of the nursing work environment [3]. A positive ethical climate is essential in nursing, as it significantly influences job satisfaction, decision-making, turnover intention, and the quality of patient care [4, 5]. Conversely, a poor ethical climate can lead to increased moral distress, professional dissatisfaction, and job burnout [6, 7]. Additionally, five distinct types of ethical climate have been identified including caring, where decisions are based on concern for others; law and code, which emphasizes adherence to professional standards; rules, which prioritize organizational policies; instrumental, where self-interest and organizational gain take precedence; and independence, which allows individual moral judgment to guide action. Research indicates that these types affect nurse behaviors in distinct ways depending on the organizational context. For example, in private hospitals, a law and code climate has a stronger influence on nurses' adherence to professional standards and expected service behaviors. In contrast, independence-oriented climates, where nurses are encouraged to act based on their own ethical judgment and professional standards, are more prevalent in public hospitals [8].

A favorable work environment characterized by adequate staffing, professional autonomy, supportive management, and interdisciplinary collaboration has been recognized as a key factor affecting outcomes for nurses, patients, and the health care organization [9, 10]. These environments have been consistently linked to higher job satisfaction, greater organizational commitment, and reduced intention to leave among nurses [11]. Moreover, a positive work environment is strongly associated with improved quality of nursing care, enhanced patient safety, and better promotion of self-care abilities. Such environments also contribute to a lower incidence of missed care or adverse patients outcomes including medication errors, catheter-associated infections, postoperative complications, nosocomial infections, and patient falls [12, 13].

1.1. Purpose

This study aimed to examine the relationship between registered nurses' perceptions of the ethical climate and the perceived quality of nursing care, and to assess how the work environment is associated with these perceptions in the UAE.

2. Methods

2.1. Design

A quantitative, cross-sectional correlational design was employed to achieve the aim of the study. Data collection was carried out between January and April 2025.

2.2. Participants

A convenient sample of registered nurses working in hospitals and primary health care centers affiliated with the Emirates Health Services (EHS) were recruited. The inclusion criteria were (1) licensed registered nurses; (2) currently employed full-time; (3) holding a minimum of a diploma degree of nursing; (4) a minimum of one year of professional experience; and (5) a willingness to participate in the study. Based on a priori sample size calculation, it was determined that a minimum sample size of 252 participants was necessary for the study. This calculation was based on a medium effect size of 0.25, a large sample power of 0.80, a two-tailed significance level (alpha) of 0.05, and eight groups as the degree of freedom (i.e. types of clinical unit). To account for a potential 10% non-response rate due to incomplete or missing data, the adjusted sample size was increased to 278 participants.

2.3. Data Collection

The survey was created and distributed using Google Forms. Eligible participants were invited to join the study through word-of-mouth invitations at their workplace. To maintain privacy and provide easy access to the survey, nurses who verbally agreed to participate received a printed sheet with both the study link and a QR code. The online survey included an introductory page outlining all relevant information, including the study's purpose, eligibility criteria, data collection tools, as well as potential risks and benefits. Participants were instructed to read this information carefully before giving their consent. Participants confirmed their voluntary agreement to participate before proceeding with the survey.

2.4. Measures

Demographic and work-related data was collected using a form specifically developed for this study based on relevant literature. The form consisted of 14 items including: age, gender, marital status, region/country of origin, years of work experience, educational level, job title, current unit, type of healthcare facility, shift type, working hours per week, monthly individual income, the approximate number of patients typically cared for during a shift, and previous training related to biomedical and nursing ethics.

The Revised Ethical Climate Questionnaire (RECQ)[14] was used to assess nurses' perceptions of the ethical climate within their employing organization. The RECQ measures three dimensions of ethical climate including Egoism (emphasizes the organization interests), Benevolence (emphasizes employee interests), and Principled (emphasizes compliance with rules, codes, and standards) [14]. Each subscale consists of four items. Participants were asked to indicate their agreement with each item utilizing a seven-point Likert-type scale, ranging from "strongly disagree" to "strongly agree." The total RECQ scores range from 12 to 84, with higher scores indicating a more favorable perceived ethical climate.

The Practice Environment Scale of the Nursing Work Index (PES-NWI) was used to assess nurses' perception of their work environment. The PES-NWI consists of 31 items grouped into five subscales that assess critical aspects of the nursing practice environment including nurse participation in hospital affairs, nurse-manager relations, autonomy, staffing and resources, and professional development [15]. Nurses respond to the questionnaire by indicating their level of agreement with each item on a four-point scale, from 1 ('strongly agree') to 4 ('strongly disagree'). The subscale score is derived by averaging the responses to the items within that subscale. A single composite score is calculated as the mean score of these subscales mean scores. Scores range from 1 to 4, with higher values indicating greater agreement that the subscale items are present in the current job. Scores above 2.5 suggest general agreement with the presence of the characteristics measured, while scores below 2.5 indicate disagreement [16]. The PES-NWI scale showed a satisfactory reliability in this study with a Cronbach alpha of .98.

The perceived quality of nursing care was measured using the Quality Nursing Care Scale (QNCS). The QNCS consists of 48 items in six dimensions including staff characteristics, task-oriented activities, human-oriented activities, physical environment, patient outcomes, and preconditions [17]. For all statements, the response scale varied from 5 (strongly agree) to 1 (strongly disagree). The total QNCS scores range from 48 to 240, with higher scores indicating a higher perceived quality of nursing care.

2.5. Data Analysis

Data was analyzed using the Statistical Package for Social Sciences (SPSS) (version 29). Descriptive statistics including means and standard deviations were computed for continuous variables (e.g., PES-WI, QNCS, RECQ mean scores) to summarize central tendency and variability. Frequencies and percentages were calculated for categorical variables (e.g., demographics, job-related factors). Several inferential tests were employed, including correlation tests and one-way analysis of variance (ANOVA). A P value of < 0.05 was considered statistically significant in all analyses.

2.6. Ethical Considerations

Ethical approval for the study was obtained prior to data collection from both the Research Ethics and Integrity Committee at the researchers' academic institution (REIC2025-CAP10) and the EHS Institutional Review Board Committee (MOHAP/DXB-REC/D-J.J /No. 220/ 2024). Informed electronic consent was obtained from each participant before participation. No personally identifiable information, such as names, emails, or phone numbers was collected. Google Forms were configured to not require sign-in, and neither IP addresses nor email addresses were collected. To ensure the secure handling of sensitive information, encryption protocols were implemented during the transport and portability of data.

3. Findings

3.1. Characteristics of the Participants

A total of 396 participants completed the survey. Most were female (81.8%), aged 30–39 years (43.2%), married (59.8%), and held a Bachelor's degree (83.1%). The largest group had 6–10 years of nursing experience (36.1%). In terms of work setting, the largest group was assigned to the emergency department (24.0%), followed by intensive care units (20.5%), and inpatient units (18.2%). Furthermore, most participants were registered nurses (88.9%), cared for 4–6 patients per shift (36.7%), and worked 12-hour shifts (64.4%). The top nationalities were Indian (39.9%), Emirati (32.1%), and Filipino or Indonesian (14.9%). Lastly, most nurses (82.1%) reported that they had received training related to biomedical or nursing ethics, Table 1.

Table 1.
Demographic characteristics of the participants (N = 396).

Variable	Category	Frequency	Percentage
Gender	Female	324	81.8
	Male	72	18.2
Age	20-29	126	31.8
	30-39	171	43.2
	40-49	80	20.2
	50 and above	19	4.8
Marital status	Single	137	34.6
	Married	237	59.8
	Divorced	13	3.3
	Separated	7	1.8
	Widowed	2	0.5
Nationality	Emirati	127	32.1
	Arab non-Emirati	40	10.1
	South Asian (India)	158	39.9
	South African	6	1.5
	Philippine or Indonesia	59	14.9
	Other	6	1.5
Years of experience	2-Jan	61	15.4
	5-Mar	94	23.7
	10-Jun	143	36.1
	20-Nov	66	16.7
	More than 20 years	32	8.1
Level of education	Bachelor	329	83.1
	Diploma	42	10.6
	Masters	21	5.3
	Doctorate	4	1
Clinical unit	Intensive care unit (e.g., ICU, CCU, NICU, PCIU, PACU)	81	20.5
	Specialized unit (e.g., catheterization lab, endoscopy, radiology)	19	4.8
	Emergency	95	24
	Labor/delivery, post-natal	33	8.3
	Pediatrics	35	8.8
	Outpatient department	48	12.1
	Inpatient unit (medical, surgical, oncology)	72	18.2
	Operation theatre		
	Nursing management	4	1
		9	2.3
Type of healthcare facility	Specialty hospital	65	16.4
	Community hospital	39	9.8
	Secondary hospital	196	49.5
	Tertiary hospital	74	18.7
	Primary health care center	22	5.6
Job title	Registered nurse (RN)	352	88.9
	Nurse practitioner (NP)	19	4.8
	Clinical nurse specialist (CNS)	10	2.5
	Nurse Manager/Supervisor		
		15	3.8
Shift type	Day Shift (e.g., 7:00 AM - 3:00 PM)	83	21
	Evening Shift (e.g., 3:00 PM - 11:00 PM)		
	Night Shift (e.g., 11:00 PM - 7:00 AM)	15	3.8
	12-Hour Shift (e.g., 7:00 AM - 7:00 PM or 7:00 PM - 7:00 AM)		
	Rotating Shifts (Alternating between day, evening, and night shifts)	17	4.3

	Fixed Shifts (Consistent shift type without rotation)		
		255	64.4
		15	3.8
		11	2.8
Working hours per week	20 and less	61	15.4
	21-30	64	16.2
	31-40	169	42.7
	41-50	97	24.5
	More than 50hr/week	5	1.3
Number of patients per shift	1-3 Patients	104	26.3
	4-6 Patients	145	36.7
	7-10 Patients	98	24.7
	More than 10 patients	49	12.4
Prior nursing or biomedical ethics training	Yes	325	82.1
	No	71	17.9

3.2. Perceptions of Ethical Climate among Registered Nurses

The RECQ scale demonstrated high internal consistency in this study with a Cronbach's alpha of 0.99. Its subscales also showed high internal consistency, with the Benevolent, Principled, and Egoistic subscales each scoring 0.97. The participants had a mean RECQ score of 49.02 (SD = 21.97), indicating a moderate overall perception of ethical climate among nurses. The relatively wide standard deviation suggests considerable variability in how nurses perceive the ethical climate within their work environments. Additionally, the mean scores across the three RECQ subscales (i.e. egoism, principled, and benevolent) were notably comparable, indicating a balanced perception among nurses across these ethical climate dimensions, Table 2.

To examine whether perceived ethical climate varied significantly by demographic and work-related factors, an analysis of variance (ANOVA) was executed, (Table 3). The analysis revealed a statistically significant difference based on age group *(F (3, 392) = 3.801, p = .010)*, with nurses aged 40–49 years reporting significantly higher ethical climate scores than those aged 20–29 years. A significant difference was also found across types of healthcare facilities *(F(4, 391) = 11.110, p = .000)*. Post hoc comparisons revealed that nurses working in tertiary hospitals perceived the ethical climate more favorably than those working in specialty hospitals (mean difference = 11.638, p = .010), community hospitals (mean difference = 15.269, p = .002), and secondary hospitals (mean difference = 18.852, p = .001).

There was a significant effect of job title on RECQ scores *(F (3, 392) = 4.467, p = .004)*, with clinical nurse specialists scoring significantly lower than registered nurses (mean difference = 24.869, p = .002). Weekly working hours were also significantly associated with RECQ scores *(F(4, 391) = 7.471, p = .000)*. Post hoc analysis showed that nurses working 41–50 hours reported significantly higher ethical climate scores compared to those working 20 hours or less (mean difference = 17.794, p < .001) and those working 31–40 hours (mean difference = 11.368, p < .001). Moreover, the number of patients cared for in a typical shift also showed a significant association *(F(4, 391) = 2.693, p = .031)*. Nurses caring for 7–10 patients had significantly lower RECQ scores (mean difference = 8.675, p = .039) compared to those caring for 1–3 patients. Finally, there was a statistically significant difference in RECQ scores based on whether participants had received training in biomedical health or nursing ethics *(F(1, 394) = 24.845, p = .000)*. Nurses who had received ethics training reported significantly higher RECQ scores (mean = 51.52) compared to those who had not (mean = 37.59).

Table 2.
Descriptive statistics of RECQ.

	Minimum	Maximum	Mean	SD	Cronbach's alpha
RECQ_Egoism	4	28	16.13	7.220	0.971
RECQ_Principled	4	28	16.52	7.502	0.977
RECQ_Benevolent	4	28	16.38	7.448	0.977
RECQ_Composite	12	84	49.02	21.965	0.991

Table 3.
Differences in perceived ethical climate by nurses' demographic and work-related variables.

Variable	Category	Mean	SD	df	F	Sig.
Age group	20–29	45.66	23.18	3	3.801	0.010
	30–39	48.51	20.82			
	40–49	55.94	20.68			
	50 and above	46.84	24.11			
Gender	Female	48.15	22.21	1	2.858	0.092
	Male	52.97	20.46			
Marital status	Single	46.20	23.39	4	1.451	0.217
	Married	49.99	21.47			
	Divorced	53.38	11.94			
	Separated	58.14	21.48			
	Widowed	67.00	7.07			
Years of professional experience	1–2 years	43.41	22.72	4	2.019	0.091
	3–5 years	48.44	21.66			
	6–10 years	48.79	21.72			
	11–20 years	53.32	20.96			
	More than 20 years	53.63	23.08			
Level of education	Diploma	54.00	21.03	3	1.132	0.336
	Bachelor's	48.68	22.03			
	Master's	46.29	21.77			
	Doctorate	39.00	26.60			
Clinical unit	Critical care	55.01	20.68	8	1.924	0.055
	Specialized	42.16	19.15			
	Emergency	46.73	22.44			
	Labor/delivery	52.85	20.53			
	Pediatrics	52.09	22.21			
	Outpatient	43.83	22.81			
	Inpatient	48.44	21.26			
	Operating theater	51.00	26.16			
	Nursing management	39.33	27.90			
Type of healthcare facility	Community	47.23	23.13	4	11.110	0.000
	Specialty	50.86	24.08			
	Secondary	43.65	19.64			
	Tertiary	62.50	18.83			
	Primary health care center	49.32	24.41			
Job Title	Registered nurse	49.97	21.57	3	4.467	0.004
	Nurse practitioner	46.53	22.67			
	Clinical nurse specialist	25.10	14.15			
	Nurse manager/supervisor	45.93	26.55			
Shift Type	Day	47.47	21.19	5	1.920	0.090
	Evening	41.47	22.25			
	Night	36.41	21.05			
	12-Hour	50.81	21.79			
	Rotating	49.55	27.94			
	Fixed	49.02	21.96			
Weekly Working Hours	≤20	40.36	16.90	4	7.471	0.000
	21–30	49.19	22.78			
	31–40	46.79	22.05			
	41–50	58.15	21.15			
	>50	51.00	25.27			
Number of patients cared for during the shift	1–3	53.97	21.00	4	2.693	0.031
	4-6	47.30	21.76			
	7-10	45.30	22.03			
	More than 10	52.14	23.59			
	Not applicable	45.13	20.20			

Ethics training	Yes	51.52	21.784	1	24.845	0.000
	No	37.59	19.094			

3.3. Nurses' Perceptions of Their Work Environment

The Practice Environment Scale of the Nursing Work Index (PES-NWI) demonstrated satisfactory internal consistency in this study, with a Cronbach's alpha of 0.988 for the overall scale. All five subscales also exhibited high reliability, Table 4.

Per the scoring guidelines Lake and Friese [16] where scores above 2.5 indicate a positive work environment, the overall PES-NWI mean score of 2.94, with subscale scores ranging from 2.87 to 2.96, suggests that nurses generally perceive their work environment as favorable. Strengths were noted in areas such as nurse participation in hospital affairs, leadership support, and foundations for quality care. However, the slightly lower score on staffing and resource adequacy (2.87) highlights a potential area for improvement to further enhance the overall work environment.

Table 4.
Descriptive statistics of PES-NWI.

	Mean	SD	Cronbach Alpha
Nurse participation in hospital affairs	2.96	0.671	0.969
nursing foundations for quality of care	2.95	0.676	0.978
Nurse manager visibility	2.96	0.693	0.959
Nurse staffing and resource adequacy	2.87	0.726	0.952
Nurse-physician collegial relations	2.93	0.686	0.926
PES_NWI composite score	2.94	0.642	0.988

3.4. Perceived Quality of Nursing Care

The reliability analysis for the NQC composite scale showed satisfactory internal consistency, with a Cronbach's alpha of 0.99. Similarly, all subscales demonstrated high internal consistency, each with a Cronbach's alpha of 0.98 or higher, Table 5.

The overall NQC composite mean score was 129.08, with subscale scores ranging from 16.78 to 27.58, indicating generally favorable perceptions of nursing care quality. Among the subscales, staff characteristics received the highest mean score (27.58), suggesting strong confidence in nurses' competence, collaboration, and reliability. Conversely, human-oriented activities had the lowest mean score (16.78), pointing to potential areas for improvement in patient-centered aspects of care such as emotional support, empathy, and individualized attention. These findings reflect a solid foundation of quality nursing practice, while identifying humanistic care as an area for focused development.

Table 5.
Descriptive statistics of NQC.

Scale/Subscale	Minimum	Maximum	Mean	SD	Cronbach's Alpha
NQC physical environment	6	30	20.51	6.827	0.980
NQC staff characteristics	8	40	27.58	9.225	0.989
NQC Precondition	7	35	23.59	7.874	0.983
NQC task oriented activities	6	30	20.34	6.858	0.984
NQC human oriented activities	5	25	16.78	5.586	0.980
NQC patient outcomes	6	30	20.27	6.693	0.982
NQC composite score	38	190	129.08	41.802	0.996

3.5. Relationship between Perceived Ethical Climate, Perceived Work Environment, and Perceived Quality of Nursing Care

A Pearson correlation analysis was conducted to examine the relationship between the nurse work environment (PES-NWI composite score) and the Revised Ethical Climate Questionnaire (RECQ) composite score. Results indicated a positive and statistically significant correlation between the two ($r = .213$, $p < .001$). Significant positive correlations were also found between the PES-NWI subscales and the RECQ composite score: nurse participation in hospital affairs ($r = .182$, $p < .001$), nursing foundations for quality of care ($r = .221$, $p < .001$), nurse manager ability, leadership, and support of nurses ($r = .200$, $p < .001$), nurse staffing and resource adequacy ($r = .168$, $p = .001$), and collegial nurse-physician relations ($r = .228$, $p < .001$). Further analysis revealed statistically significant positive correlations between the PES-NWI composite score and the RECQ subscales: Principled ($r = .222$, $p < .001$), Benevolent ($r = .210$, $p < .001$), and Egoism ($r = .202$, $p < .001$) ethical climate dimensions, Table 6.

Similarly, Pearson correlation analysis was conducted to examine the relationship between the RECQ composite score and the Nursing Quality of Care (NQC) composite score. A strong positive correlation was found between the two variables ($r = .727$, $p < .001$). Significant positive correlations were also observed between the RECQ composite score and the NQC subscales: physical environment ($r = .730$, $p < .001$), staff characteristics ($r = .716$, $p < .001$), preconditions for quality care ($r = .704$, $p < .001$), task-oriented activities ($r = .694$, $p < .001$), human-oriented activities ($r = .689$, $p < .001$), and patient outcomes ($r = .694$, $p < .001$), Table 6.

Table 6.
Correlations Between PES-NWI, RECQ, and NQC.

Scale / Subscale	RECQ Composite	RECQ Principled	RECQ Benevolent	RECQ Egoism
PES-NWI Composite Score	0.213**	0.222**	0.210**	0.202**
Nurse participation in hospital affairs	0.182**	—	—	—
Nursing foundations for quality care	0.221**	—	—	—
Nurse manager ability, leadership, and support	0.200**	—	—	—
Nurse staffing and resource adequacy	0.168**	—	—	—
Collegial Nurse-Physician Relations	0.228**	—	—	—
NQC composite score	0.727**	—	—	—
Physical environment	0.730**	—	—	—
Staff characteristics	0.716**	—	—	—
Precondition	0.704**	—	—	—
Task-oriented activities	0.694**	—	—	—
Human-oriented activities	0.689**	—	—	—
Patient outcomes	0.694**	—	—	—

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

To further examine these relationships, a multiple linear regression analysis was conducted with perceived ethical climate, perceived work environment, years of experience, level of education, gender, marital status, type of clinical unit, country/region of origin, type of clinical facility, job title, average number of patients care for per typical shift, number of weekly working hours, and shift type as predictors of perceived quality of nursing care. Diagnostic tests were performed to assess the assumptions of linearity, multicollinearity, homoscedasticity, normality, and residual independence prior to the regression analysis. Scatterplots were visually inspected for linearity, and the Variance Inflation Factor (VIF) was used to measure multicollinearity. All VIF values ranged between 1 and 1.70, indicating no concerns with multicollinearity. The Durbin-Watson test, used to assess the independence of residuals, showed no significant deviations from this assumption (value= 1.93). A hierarchical multiple regression was used to create the regression model. In Step 1, demographic and work-related variables were entered into the model to control for their effects. Ethical climate and work environment were added in Step 2.

In Step 1, demographic and work-related variables explained 24.6% of the variance in perceived quality of nursing care. After adding ethical climate and work environment in Step 2, the model explained an additional 35.1% of the variance, with a total of 59.7% of the variance explained, $F(2, 380) = 165.22$, $p < .001$. Perceived ethical climate had the strongest positive association with perceived quality of care ($\beta = .634$, $p < .001$), followed by years of experience ($\beta = .151$, $p < .001$), and work environment ($\beta = .088$, $p = .017$). Having received biomedical ethics training was negatively associated with perceived quality of care ($\beta = -.130$, $p < .001$). Additionally, the number of patients cared for was negatively related to perceived quality ($\beta = -.071$, $p < .001$), indicating that caring for more patients was associated with a lower perception of nursing care quality, Table 7.

Table 7.
Predictors of perceived quality of nursing care.

Variable	B	SE	β	t	p
(Constant)	68.868	13.919	—	4.948	< 0.001
Gender	3.630	3.857	0.034	0.941	0.347
Marital status	-2.018	2.336	-0.032	-0.864	0.388
Country/region of origin	0.545	1.228	0.018	0.444	0.657
Years of experience	7.781	1.513	0.212	5.141	<0.001
Education level	-3.945	3.368	-0.042	-1.171	0.242
Type of clinical unit	-0.632	0.626	-0.035	-1.009	0.313
Type of health care facility	-1.160	1.300	-0.030	-0.892	0.373
Job title	-2.214	2.251	-0.035	-0.983	0.326
Shift type	-1.102	1.188	-0.035	-0.927	0.354
Working hours/week	0.200	1.742	0.005	0.115	0.909
Number of patients cared for during the shift	-2.534	1.283	-0.071	-1.975	0.049
Training related to nursing/biomedical ethics	-14.139	3.923	-0.130	-3.604	<0.001
Work Environment (PES-NWI mean score)	5.721	2.396	0.088	2.387	0.017
Ethical Climate (RECQ Composite score)	1.207	0.069	.634	17.480	< .001

4. Discussion

The purpose of this study was to examine the association between registered nurse's perception of their organization's ethical climate and the work environment and their perceived quality of nursing care. Participating nurses generally perceived the ethical climate of their healthcare settings as moderate, with notable variability based on demographic and

organizational factors. The comparable mean scores across the RECQ subscales: egoism (16.13), principled (16.52), and benevolent (16.38) suggest a balanced and consistently positive ethical climate perceived by nurses. This minimal variance indicates that ethical rules, relational care, and opportunities for personal growth are equally valued. Such alignment may reflect institutional efforts, like those by Emirates Health Services (EHS), to promote professional development, staff well-being, and ethical practice across all dimensions.

The highest RECQ mean scores were observed among nurses working in tertiary hospitals, where more structured ethical frameworks, access to ethics training, strong leadership, and comprehensive staff support systems are typically available. These findings align with previous research emphasizing the vital role of organizational structure and a supportive ethical climate in enhancing nurses' work-related quality of life, reducing stress, and contributing to improved organizational outcomes such as increased employee satisfaction and operational efficiency, ultimately influencing the quality of care [18, 19]. Further, in concordance with previous research [20, 21] nurses who had received formal ethics training reported significantly higher RECQ scores compared to those without such training. This difference could be attributed to the value of continuous professional development in fostering ethical awareness, enhancing confidence in ethical decision-making, and promoting alignment with institutional values.

While a significant relationship was found between age and ethical climate perception in the current study, this association did not extend to years of clinical experience. This finding contrasts with prior studies by Maisonneuve, et al. [19] and Fradelos, et al. [22] which reported that departmental tenure or experience moderates the influence of ethical climate. The lack of similar association in the current study highlights a divergence from existing literature and warrants further exploration into other possible mediating factors such as differences in organizational culture, leadership, availability of ethics training, or the extent of nurses' exposure to ethical decision-making processes. Nurses who cared for an average of 1-3 patients per shift reported significantly higher RECQ scores compared to those caring for 7-10 patients. This finding aligns with studies by Maisonneuve, et al. [19] and Hou, et al. [23] which reported significant correlations between ethical climate, individualized care, and the perceived quality of nursing care, especially when workloads are manageable. These results suggest that lower patient loads enable more personalized, ethically sound care and allow nurses to engage more deeply in ethical decision-making, while also reducing stress and the risk of ethical compromise. Surprisingly, clinical nurse specialists (CNS) in this study reported lower ethical climate perceptions compared to registered nurses. This finding could be attributed to CNS's dual clinical and leadership responsibilities, which can increase their exposure to ethically complex decisions and organizational constraints, thereby heightening moral sensitivity and stress.

An improvement in the work environment was associated with a corresponding increase in nurses' overall perception of the ethical climate including each subscale of the RECQ (i.e. benevolent, principled, egoism). Although the correlation was modest, the findings suggest that a supportive work environment positively influences how ethical practices are perceived. In this study, nurses generally rated their work environments favorably, particularly in areas such as nurse participation in hospital affairs, collegial nurse-physician relationships, and the foundations for quality care, reflecting meaningful inclusion in decision-making processes, professional autonomy, and moral accountability. This aligns with prior evidence that ethical climate is shaped not only by individual factors, such as internal motivation and ethical sensitivity, but also by work factors, including strong leadership support and collegial nurse-physician relationships [6, 24, 25]. Leadership support plays a particularly critical role in fostering a psychologically safe environment where nurses feel empowered to report concerns or errors without fear of punitive consequences. The implementation of non-punitive, transparent systems not only build trust within the organization but also contributes to the advancement of ethical standards and the consistency of care delivery [26].

Study findings revealed significant associations across all subscales of the NQC and perceived ethical climate, suggesting that a strong ethical foundation in nursing practice supports not only the quality of care but also patient-centered outcomes and professional conduct. The results of the regression analysis further confirmed these relationships, revealing that ethical climate perception accounted for the largest proportion of variance in perceived quality of nursing care ((β = .634, p < .001). This aligns with findings from several studies indicating that organizations that cultivate a positive ethical climate not only improve job performance and professional behavior but also enhance the quality of care [8, 19, 27].

5. Limitations

Despite its valuable contributions to a relatively underexplored area within the UAE, offering insights that can inform both nursing policy and practice, the study had several limitations. The study employed a convenience sampling method, which may introduce selection bias and affect the representativeness of the sample. Additionally, the inclusion of nurses solely from Emirati Health services (EHS) may also restrict the generalizability of the findings to all registered nurses within the UAE. Future research employing longitudinal designs and more diverse, randomized samples is recommended to validate and extend these findings.

6. Conclusions

This study underscores the critical influence of ethical climate and the nursing work environment on registered nurses' perceptions of care quality in the UAE. The results reveal that a positive ethical climate, particularly in environments that promote leadership support, participation, and teamwork, is strongly associated with higher perceived quality of nursing. Focusing on aspects such as emotional support and nurse engagement can improve quality of care, mitigate ethical concerns, and increase job satisfaction, potentially leading to improved patient outcomes and a stronger nursing workforce.

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