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Jaana Koskenniemi

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In the absence of respect, nursing cannot take place
Adapted by Brighid Kelly
1990

For all my colleagues in nursing practice and science

UNIVERSITY OF TURKU
Faculty of Medicine, Department of Nursing Science
Nursing Science
JAANA KOSKENNIEMI: Respect in nursing care as perceived by older patients
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ABSTRACT

To be cared for with respect is considered a primary right of patients, and showing respect is a professional requirement in the delivery of ethical high-quality care. The aim of this study was to analyse respect in nursing care as perceived by older patients (≥ 65 years) and to develop and test an instrument for its evaluation. The study was organised in three phases. In the first phase, the theoretical basis for evaluation of respect as perceived by older patients was developed by interviewing older patients and their next of kin. Two data sets, the first n=20 (10 older patients and 10 next of kin) and the second n=40 (20 older patients and 20 next of kin) were collected in different care settings and analysed using inductive content analysis followed by the construction of a typology. In the second phase, the ReSpect Scale was developed for the measurement of older patients' perceptions of respect in the care provided by nurses. Two rounds of expert panels (n=10 and n=5) and a pilot test (n=30) were organised to improve the ReSpect Scale. In the third phase, the ReSpect Scale was tested, perceptions of respect and factors associated with perceived respect were analysed among older hospitalised patients (n=196) using statistical methods.

The results revealed that respect is a multidimensional concept involving several nurse- and next of kin-related actions, as well as environment-related factors. Respect manifested itself in patient-nurse relationships as a mutual understanding by facilitating patient independence and active participation in care. The ReSpect Scale showed potential as an instrument with which to explore the extent to which older patients perceived respect in nurses' ways of being with patients (nurses' essence and nurses' commitment) and doing for patients (accepting, listening, encouraging, and nurturing them). Overall older patients felt respected by their nurses, however, there was also need for improvements. It is remarkable that the older patients who perceived their health status to be poor tended to perceive respect significantly less frequently than patients perceiving their health status to be better. A strong positive correlation between perceived respect and perceived satisfaction was found.

This study created a theoretical basis for respect in nursing care as perceived by older patients and an approved instrument for measuring it. The identification and measurement of respect and its associated factors may make respect more visible in nursing care and improve respectful encounters in health care.

KEYWORDS: respect, ethics, nursing care, older patients, instrument

TURUN YLIOPISTO
Lääketieteellinen tiedekunta, Hoitotieteen laitos
Hoitotiede
JAANA KOSKENNIEMI: Kunnioittava kohtelu hoitotyössä ikääntyneen potilaan näkökulmasta
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Hoitotieteen tohtoriohjelma
Lokakuu 2021

TIIVISTELMÄ

Kunnioittava kohtelu on potilaiden perusoikeus ja hoitajien velvollisuus eettisesti korkeatasoisessa hoitotyössä. Tämän tutkimuksen tarkoituksena oli analysoida kunnioittavaa kohtelua hoitotyössä ikääntyneen potilaan näkökulmasta, kehittää sen arviointiin mittari ja testata sitä. Tutkimus toteutettiin kolmessa vaiheessa. Ensimmäisessä vaiheessa luotiin teoreettinen perusta kunnioittavan kohtelun arvioimiseksi hoitotyössä ikääntyneiden potilaiden näkökulmasta. Kaksi haastattelu-tutkimusta, ensimmäinen n=20 (10 ikääntynyttä potilasta ja 10 heidän läheistään) ja toinen n=40 (20 ikääntynyttä potilasta ja 20 heidän läheistään) toteutettiin haastattelemalla tutkittavia erilaisissa hoitotyön ympäristöissä. Aineistot analysoitiin sisällön analyysillä ja muodostamalla typologia. Toisessa vaiheessa kehitettiin ReSpect-mittari arvioimaan ikääntyneiden potilaiden käsityksiä kunnioittavasta kohtelusta hoitajan tavassa olla ja toimia heidän kanssaan. Mittarin kehittämisessä hyödynnettiin kahden asiantuntijaryhmän (n=10 ja n=5) asiantuntemusta ja mittari pilotoitiin sairaalapotilailla (n=30). Kolmannessa vaiheessa mittaria testattiin (n=196 sairaalapotilasta) ja ikääntyneiden potilaiden käsityksiä kunnioittavasta kohtelusta ja siihen yhteydessä olevia tekijöitä analysoitiin tilastollisin menetelmin.

Tulokset osoittavat kunnioittavan kohtelun olevan moniulotteinen käsite, joka sisältää useita potilaaseen, läheiseen ja hoitotyön ympäristöön liittyviä tekijöitä. Kunnioittava kohtelu ilmeni potilaan ja hoitajan välillä yhteisymmärryksenä vahvistaen potilaan riippumattomuutta ja aktiivista hoitoon osallistumista. ReSpect-mittari osoittautui kehittämisen arvoiseksi arvioimaan käsityksiä kunnioittavasta kohtelusta hoitajan tavassa olla (hoitajan olemus ja sitoutuminen) ja toimia (hoitajan tapa osoittaa hyväksyntää, kuunnella aktiivisesti, rohkaista ja huolehtia) ikääntyneen potilaan kanssa. Kokonaisuutena ikäihmiset kokivat tulleensa kunnioittavasti kohdelluiksi, mutta myös kehittämistarpeita ilmeni. Huomioitavaa kuitenkin on, että terveytensä heikoksi kokeneet potilaat kokivat tulleensa harvemmin kunnioittavasti kohdelluiksi kuin terveytensä paremmaksi kokeneet. Kunnioittavan kohtelun ja potilastyytyväisyyden välillä havaittiin vahva positiivinen yhteys.

Tutkimus loi teoreettisen perustan ikääntyneiden potilaiden näkemyksille kunnioittavasta kohtelusta hoitotyössä ja osoitti käsitteen mitattavuuden. Määrittelemällä ja mittaamalla kunnioittavaa kohtelua potilaiden hoitotyössä voidaan edistää kunnioittavia kohtaamisia terveydenhuollossa.

AVAINSANAT: Kunnioittava kohtelu, hoitotyön etiikka, ikääntynyt potilas, mittari

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Abbreviations

ALLEA	European Federation of Academies of Sciences and Humanities
ANA	American Nurses Association
ANOVA	Analysis of variance
CBI	Caring Behaviours Inventory
CBI-RDO	Caring Behaviours Inventory-Respectful Deference to Others
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CORDIS	European Commission research results
EQ-5D-5L	EuroQol-5D-5L scale
ETENE	National Advisory Board on Social Welfare and Health care Ethics
ICN	International Council of Nurses
MEDLINE	Medical Literature Analysis and Retrieval System Online
MMSE	Mini Mental State Examination
PCA	Principal Component Analysis
PSS	Patient Satisfaction Scale
RTPC	RightTimePlaceCare – Improving health service for European citizens with dementia
SAS	Statistical Analysis Software
TENK	Finnish National Board on Research Integrity
TUKIJA	National Committee on Medical Research Ethics
VAS	Visual analogue scale
WHO	World Health Organization
WMA	The World Medical Association

List of Original Publications

This dissertation is based on the following original publications, which are referred to in the text by their Roman numerals:

I Koskenniemi J, Leino-Kilpi H & Suhonen R. 2013. Respect in the care of older patients in acute hospitals. Nursing Ethics 20 (1), 5–17. doi: 10.1177/0969733012454449.

II Koskenniemi J, Leino-Kilpi H & Suhonen R. 2015. Manifestation of respect in the care of older patients in long-term care settings. Scandinavian Journal of Caring Sciences 29 (2), 288–296. doi:10.1111/scs.

III Koskenniemi J, Leino-Kilpi H, Puukka P, Stolt M & Suhonen R. 2018. Being respected by nurses: measuring older patients' perceptions. International Journal of Older People Nursing 13(3): e12197, doi.org/10.1111/opn.12197

IV Koskenniemi J, Leino-Kilpi H, Puukka P, & Suhonen R. 2019. Respect and its associated factors as perceived by older patients. Journal of Clinical Nursing 28(21–22), 3848–3857, doi.org/10.1111/jocn.15013

1 Introduction

This is a study about respect in the nursing care of older patients, inspired by older patients and their experiences of respect in nursing practice. As the largest group of patients in our healthcare system older patients have a right to be heard, and their perceptions of the central ethical concept in nursing care to be investigated. The aim of this study was to analyse respect in nursing care as perceived by older patients, and to develop and to test an instrument for its evaluation.

Respect is acknowledged worldwide as a fundamental human value and a basic human right that all people are born with and retained it throughout their life. The right to respect is fundamental to all human being regardless of their race, gender, language, religion, opinion, or social status (Universal Declaration of Human rights 1948). The need to respect patients within health care is highlighted in the rights of patients (Act on the Status and Rights of Patients 785/1992, WHO 1994; Charter of Fundamental Rights 2010; Ministry of Social Affairs and Health 2013) and in policy papers in all European countries (European Commission, Healthy ageing 2007; European Commission, White paper 2007; WHO 2015). Moreover, an obligation to show respect is emphasised in the ethical statements (Hippocratic oath [Solin 1984], Principles of Health Care Ethics [ETENE 2001]) and in the codes of ethics for health care professionals (ICN 2012, ANA 2015). However, neglect concerning respect in older patients' care have been topics of daily news in Europe (e.g. Francis 2013, NMC 2013, Medicolegal Partners 2020) and occasionally in Finland as well; these concerns have also been supported in empirical studies (Teeri et al. 2006, 2008, Ausserhofer et al. 2013, Reader & Gillespie 2013, Harrison et al. 2016).

Although respect is defined as a central concept and an essential value in nursing care (Browne 1993, Downie et al. 1994, Thompson et al. 2006, Fry & Johnstone 2008), it has seldom been a topic of nursing research (Browne 1993, Gallagher 2004, Gallagher et al. 2008, Wainwright & Gallagher 2008). Instead, respect has been defined and described as part of other concepts, such as good nursing care (Leino-Kilpi 1990) and individualised care (Suhonen 2002), and within other important values in nursing, such as human dignity (Coventry 2006, DiBartolo 2006, Kalb & O'Conner-Von 2007), integrity (Teeri et al. 2006, 2008), autonomy (Välimäki et al.

2001, Leino-Kilpi et al. 2003, Scherwin &Winsby 2010) and self-determination (Välimäki 1998, Hellström & Sarvimäki 2007, Welford et al. 2010).

Respect is a multidimensional ethical concept and manifests itself in dialogical relationships (Dillon 1992) through attitudinal, cognitive, and behavioural orientations towards other people (Browne 1993). In nursing care, respect is perceived through nurses' verbal and nonverbal communication and in nursing actions in daily care interactions with patients (Browne 1993, Browne 1995, Gallagher 2007, Gallagher et al. 2008). Respect has been associated with positive emotional interaction between the patient and the staff (Hansebo & Kihlgren 2002, Nolan et al. 2004, Solum et al. 2008, Dickert & Kass 2009, Bridges et al. 2010, Jonasson & Berterö 2012) where patients' perceptions (Heiselman & Noelker 1991, Thompson et al. 2011, Papastavrou et al. 2012, Beach et al. 2015) and their personal needs (Kvåle & Bondevik 2008, Thompson et al. 2011, Papastavrou et al. 2012) were considered with sensitiveness and responsiveness, and where they were listened to attentively (Heiselman & Noelker 1991, Kvåle & Bondevik 2008, Thompson et al. 2011, Papastavrou et al. 2012, Beach et al. 2015) and encouraged to express their personal wishes and hopes (Heiselman & Noelker 1991, Kvåle & Bondevik 2008). However, care is not always delivered respectfully (DeHart et al. 2009, Buzgova & Ivanova 2011) and many complaints focus on patient-health care relationships (Ausserhofer et al. 2013, Kahn et al. 2015, Harrison et al. 2016) especially disrespectful communication and behaviour (Reader et al. 2014).

Definitions and descriptions of respect are fragmented in empirical nursing literature, and perceptions of respect have mostly been evaluated from the perspective of the staff (Baillie et al. 2009, Person & Finch 2009, Jakobsen & Sorlie 2010) and within different cultures (Browne 1997, Foronda 2008). Respect in nursing care from the older patients' point of view has rarely been studied (Hallström & Elander 2001, Gallagher & Seedhouse 2002, Bridges et al. 2010, Jonasson et al. 2010, Spichiger 2010, Thompson et al. 2011). Moreover, there is a lack of instruments measuring perceptions of respect (Browne 1993, Duffy et al. 2007; Aboumatar et al. 2015).

Defining and operationalising respect in nursing care is challenging due to its abstract nature (Browne 1993, Gallagher et al. 2008). Perceptions of respect are always personal depending on person's own values, attitudes, and individual experiences. Moreover, respect is context bound and dependent on the environment. However, respect for patients is sufficiently important to be studied as a single element of care (Duffy et al. 2007, Aboumatar et al. 2015). By knowing what respect is and how it is perceived by patients make it possible to enhance respect and ethical quality in nursing care.

Evaluating respect within other concepts in nursing care may raise its profile and facilitate its identification and measurement. Earlier literature indicates that by respecting patients' perceptions of their needs or personal values associated with

their health and illness may promote patients' health (e.g. Kvåle & Bondevik 2008, DeHart et al. 2009, Buzgova & Ivanova 2011, Oosterveld-Vlug et al. 2014) and lead to satisfaction with the received nursing care (e.g. Johansson et al. 2002, Berglund 2007, Kahn et al. 2015).

This study analysed respect in nursing care as perceived by older patients and offers an approach with regard to how it can be measured. The older patients in this study were 65 years or older, based on the general retirement age in Finland (National Pension Act 568/2007). Older patients' point of view was selected, because they are the largest group of patients and users of the health care services in our healthcare system (MSAH 2020, OECD 2020), and their views need to be highlighted. Moreover, based on their longer life and life experiences they may have valuable information on respect and its manifestation. Further, the fragility following health problems and hospital care at a later age in life brings special needs which must be taken into consideration in older patients' care. Responses to these needs also reflect the extent to which a caring culture is present in older patients' nursing care. Older patients are considered vulnerable to overtreatment, under treatment, mistreatment, or omissions in care (DiBartolo 2006, Suhonen et al. 2018). According to the literature ageism (Bayer et al. 2005, Buzgova & Ivanova 2011, WHO 2021) and even neglect (Papastavrou et al. 2012, Kalankova et al. 2020) have been reported, thus pointing out a lack of respect for older patients.

To analyse respect in nursing care as perceived by older patients, the study is organized in three phases (Figure 1.). In the first, the conceptual phase, respect in nursing care was defined from the older patients' point of view and its manifestation was described in a patient-nurse relationship. In the second, the instrumentation phase, respect was operationalized from the point of view of older patients as they perceived respect in the care delivered by nurses, and the ReSpect Scale was developed. In the third, the evaluation phase, the ReSpect Scale was tested and associations between perceived respect, perceived health status and perceived satisfaction with nursing care were examined. To these ends two interview studies were conducted to develop the theoretical basis of respect as perceived by older patients (Phase I), two expert panels and a pilot test evaluated the ReSpect Scale (Phase II), and one cross-sectional survey tested the ReSpect Scale and examined its associated factors (Phase III). The literature on respect and nursing are utilised in every phase of the study to obtain an understanding of respect in the nursing care of older patients.

In this study respect has been investigated as "kunnioittava kohtelu" in Finnish. "Kunnioittava" refers to respectful, and "kohtelu" refers to actions and ways to convey respect to another human being. Thus, the basis for respect in this study is its ethical nature and its manifestations in interactions between patients and nurses.

This is a study of nursing ethics in the context of older peoples' nursing care.

LITERATURE

The purpose was to analyse respect in nursing care as perceived by older patients and to develop and to test an instrument for its evaluation.

Phase I CONCEPTUAL PHASE (2009-2015) **Papers I, II**
Aim: To define and describe respect in nursing care from older patients' point of view.

Substudy 1: Interview study, Definition of the concept of respect (Paper I)
Aim: To define respect in the nursing care of older patients
Design: Descriptive based on open interviews
Sample: Older patients in acute hospital setting (n=10), next of kin (n=10)

Substudy 2: Interview study, Manifestation of respect in a patient-nurse relationship (Paper II)
Aim: To describe the manifestation of respect in a patient-nurse relationship
Design: A narrative inquiry using open interviews
Sample: Older patients in long-term care settings (n=20), next of kin (n=20)

Phase II INSTRUMENTATION PHASE (2013-2016) **Paper III**
Aim: To develop an instrument for the measurement of respect as perceived by older patients

Instrument development (Paper III)
Design: Methodological by using expert panels and pilot testing
Sample: Experts in nursing ethics (n=15), two rounds and a pilot test with older hospital patients (n=30)

Phase III EVALUATION PHASE (2016-2018) **Papers III, IV**
Aim: To evaluate respect and its associated factors as perceived by older patients.

Survey study with structured face-to-face interviews (Papers III, IV)
Design: A cross-sectional, descriptive, correlational survey based on individual interviews using structured questionnaires
Instruments: The ReSpect Scale, The CBI-Respectful Deference to Others (CBI-RDO), EuroQol 5D-5L, Patient Satisfaction Scale (PSS)
Sample: Hospitalised older patients (n=200)

The outcomes achieved were the perceptions of respect expressed by older patients in nursing care, a theoretical basis for this and the tested ReSpect Scale.

(Papers I, II, III, IV, Summary)

Figure 1. Study design

2 The Concept of Respect

This chapter presents an analysis of the concept of respect found in earlier literature in order to understand its abstract nature and multidimensionality. This has been done by describing the definitions of the concept of respect (2.1) and the manifestations of respect in earlier literature (2.2). Finally, the conceptual basis of respect for this study is summarised (2.3). The literature utilised in this chapter consists of legislation, care policies and strategies, ethical statements and professional values, concept analysis, reviews, and references to the empirical articles reviewed in Chapter 3.

2.1 Definitions of the concept of respect

Dictionary definitions of respect and the uses of the concept illustrate the descriptions of the concept of respect. Dictionary definitions of respect have been analysed so as to investigate the origin of the concept of respect and the uses of the concept will deepen ethical aspects of respect.

Dictionary definitions of respect

The dictionaries defining respect in this study, were selected based on both their general (Sanakirja.org) and academic (MOT Oxford Thesaurus of English) usage. Moreover, a Standard Dictionary was also selected so as to present the class meaning of the concept.

Respect originates from the Latin “respicere”, which means ‘to look back at’ or ‘to look again’, ‘to re-spect’. The idea of looking also occurs in the words used synonymously with respect. For example, the synonym ‘regard’ means ‘to watch out for’ and the synonym ‘consider’ means ‘examine carefully’. (Dillon 1992, 108.)

Dictionaries define respect as a noun, a verb, and an adjective (Table 1.). As a noun, respect is defined as an attitude of consideration or high regard (Sanakirja.org), a just regard for and appreciation of worth, honor and esteem (Standard Dictionary). Respect indicates expressions of esteem, favourable opinions or estimations based on worth, especially that based on moral characteristics. Respect is defined as demeanour or deportment indicating deference and respectful yielding, willingness

to carry out the wishes of others. Further, respect has been defined as conformity to duty or obligation, and as compliance or observance. Moreover, respect is a condition of being honoured or respected. (Standard Dictionary.) Antonyms for respect as a noun are contempt, an act of despising; and disrespect, rude behaviour and impoliteness (Standard Dictionary, MOT Oxford Thesaurus of English).

As a verb respect is to have respect for (Sanakirja.org), to esteem, and to express high value (Standard Dictionary). Respect implies deferential regard for by looking at or observing closely or attentively (Standard Dictionary). Moreover, respect is to treat with propriety or consideration. Avoid harming, interfering with, or intruding upon are also aspects of respect as a verb (Standard Dictionary, MOT Oxford Thesaurus of English). Moreover, respect is to have a relation or reference to something, and concern for it (Standard Dictionary). Antonyms for respect as a verb are despise, to regard as contemptible or worthless; scorn, to hold in or treat with contempt; and ignore, to refuse to notice or recognise (Standard Dictionary, MOT Oxford Thesaurus of English).

As an adjective respectful means to be marked by respect or manifesting respect (Standard Dictionary). Respectful is to be deferential and polite. These meanings imply to be reverent, humble, and dutiful as well as courteous, considerate, and solicitous. Amenable and compliant are also relevant associations of being respectful. Antonyms for respectful are disrespectful and rude. (MOT Oxford Thesaurus of English.)

Table 1. Dictionary definitions of respect as a noun, verb, and adjective.

Respect as	Description	Reference
Noun respect	An attitude of consideration or high regard. A just regard for and appreciation of worth, honor and esteem. Expressions of esteem. Demeanor or deportment indicating deference, willingness to carry out the wishes of others. Conformity to duty or obligation; compliance or observance. The condition of being honored or respected.	Sanakirja.org Standard Dictionary MOT Oxford Thesaurus of English
Verb respect	To have respect for To esteem, to express high value. To have deferential regard for. To treat with propriety or consideration. To regard as inviolable, to avoid intruding upon. To have relation or reference to; concern.	Sanakirja.org Standard Dictionary MOT Oxford Thesaurus of English
Adjective respectful	To be marked by respect or manifesting respect. To be deferential and polite: to be reverent, humble, dutiful, courteous, considerate, solicitous. To be amenable, compliant.	Standard Dictionary MOT Oxford Thesaurus of English

In the light of the dictionary definitions, the origin of the concept of respect seems to have come from expressions of esteem and regard, and on treatment concordant with duties and obligations. Although respect is related to duties and obligations, it seems to be a pleasant and unforced responsibility expressing conformity, harmony, and flexibility.

The uses of the concept of respect

The uses of the concept of respect has been applied in earlier literature with the meaning of the right to be respected and as the obligation to show respect (Table 2.). These rights and obligations comprise the basis for respect and its manifestations in nursing care relationships.

One of the most central declarations defining the right to respect is the Universal Declaration of Human Rights (1948). Human rights secure equal dignity and rights for every human being regardless of their social position, individual characteristics, achievements, personal merits, role, or power. These rights are established on common sense and conscience principles that obligate all human beings to treat each other with kindness and respect in a spirit of unity. (United Nations 1948.)

The fundamental right to respect has been widely analysed in earlier literature and all highlight the fact that all people are born with this right and retain it

throughout their life. The fundamental point is that respect is not something that has to be earned. Respect should be given, and it is deserved even if it is not returned. (Dillon 1992, DeLellis 2000, Dillon 2007, Dillon 2018). There is also a different understanding of respect which emphasises that respect must be earned. Respect for moral stature is dependent on the subject's actions so it may alter with time and circumstances (Wainwright & Gallagher 2008). To be cared for with respect is considered an essential right of patients in health care and patients have the right to be treated so that their human dignity is not violated, and their beliefs and privacy is respected (Act on the Status and Rights of Patients 1992, WHO 2002, European Commission 2007, WHO 2015).

The fundamental moral obligation of human beings, described by Immanuel Kant as a Categorical Imperative, is to respect individuals as an end in themselves. To treat the other as an end is to value the other absolutely, unconditionally, and incomparably. Respect is to value individuals for themselves and to acknowledge them in a way that their dignity imposes absolute constraints on how they are treated. (Dillon 2007, 206, Dillon 2018.) The same idea is also expressed as a Golden Rule, a universal ethical norm, obligating individuals to treat each other as one would wish to be treated oneself (Wattles 1996).

An obligation to show respect in health care is described as a primary ethical principle (Downie & Telfer 1969, Kelly 1990, Browne 1993, Levine 1997, Principles of Health Care Ethics 2001 [ETENE 2001], Tarlier 2004, Gallagher 2007, Fry & Johnstone 2008, ICN 2012, Beauchamp & Childress 2013, ANA 2015) and as a fundamental professional value (Kelly 1990, Browne 1993, Gallagher 2007, ICN 2012, ANA 2015). As a primary ethical principle, respect is tied to the notion of doing good and avoiding harm (Downie & Telfer 1969, Kelly 1990, Browne 1993, Principles of Health Care Ethics 2001, Tarlier 2004, Gallagher 2007, Fry & Johnstone 2008). Further, respect has been defined as the central moral attitude from which all other moral principles stem (Browne 1995). As such respect in health care is an attempt to understand and accept patients' needs, to value their preferences and personal experiences, and to seek mutual understanding without any control, pressure or coercion (Principles of Health Care Ethics 2001[ETENE], ICN 2012, ANA 2015).

As a fundamental professional value respect entails considering justice for patients and their human dignity and honour (Kelly 1990, Browne 1993, Gallagher 2007). Thus, respect is bound to enhance the equality of patients' care, protect their intrinsic worthiness and the uniqueness, and promote their autonomy and capacity for self-determination (ICN 2012, ANA 2015). Respect is included in professional values aiming to maintain (Hall et al. 2014, Ferri et al. 2015), preserve (Jacelon 2004, Jacelon et al. 2004, Anderberg et al. 2007) and promote (Baillie 2009) patients' dignity, protect their integrity (Randers & Mattiasson 2004, Westin & Danielson 2007, Teeri et al.

2008), and encourage their self-determination (Välimäki et al. 2001, Randers & Mattiasson 2004, Hellström & Sarvimäki 2007, Holmberg et al. 2012).

Table 2. Examples of the uses of the concept of respect.

Uses	Description	Authors and year
Right for respect		
Basic human right	To be treated with respect is the fundamental human right for every human being irrespective of their social position, individual characteristics, attainments, personal merit, role, or power.	The Universal Declaration of Human Rights, United Nations 1948, Dillon 2007
The fundamental right for respect	Respect is not something that has to be earned. Respect should be given, and it is deserved even if it is not returned.	Dillon 1992, DeLellis 2000, Dillon 2007, WHO 2015, Dillon 2018
Essential right of patients and obligation of professionals	All patients have the right to be treated with respect in nursing care, and nurses are obligated to show respect for their patients.	Act on the Status and Rights of Patients 1992, Principles of Health Care Ethics 2001, WHO 2002, European Commission 2007, The ICN Code of Ethics for Nurses 2012, The American Nurses Association's Code of Ethics for Nurses 2015, WHO 2015
Obligations to show respect		
Categorical Imperative	Obligation to treat the other as an end in themselves. Respect is to value a person for them self and to acknowledge the person in a way that their dignity imposes absolute constraints on our treatment of them.	Dillon 2018
Golden rule, universal ethical norm	Obligation to treat others as one would wish to be treated oneself.	Wattles 1996
Primary ethical principle and central moral attitude	Obligation to do good and avoid harm. Respect attempts to understand and accept patients' needs, to value their wishes and personal experiences, and to seek mutual understanding without any control, pressure, or coercion.	Downie & Telfer 1969, Kelly 1990, Browne 1993, 1995, Levine 1997, Principles of Health Care Ethics 2001, Tarlier 2004, Dillon 2007, Gallagher 2007, Fry & Johnstone 2008, ICN 2012, Beauchamp & Childress 2013, ANA 2015
Fundamental professional value	Obligation to regard justice for patients, and their human dignity, and honour. Respect is bound to enhance the equality of patients, to protect their intrinsic worthiness and uniqueness, and to promote their autonomy and capacity for self-determination.	Kelly 1990, Browne 1993, Välimäki et al. 2001, Jacelon et al. 2004a, Randers & Mattiasson 2004, Anderberg et al. 2007 Gallagher 2007, Hellström & Sarvimäki 2007, Westin & Danielson 2007, Teeri et al. 2008, Baillie 2009, Holmberg et al. 2012, ICN 2012, Hall et al. 2014, ANA 2015, Ferri et al. 2015

The uses of the concept of respect indicate that patients have the right to be respected and professionals have an obligation to show respect for their patients. Respect is not something that has to be earned, and it should be given even if it is not returned. Respect is included in professional values with the aim of doing good and avoiding harm.

2.2 Manifestation of respect in earlier literature

Respect manifests itself as self-respect, respect for others and experiences of being respected by others. The extent to which a person believes that (s)he lives a moral and worthwhile life is the extent to which (s)he has respect for themselves (Dillon 2007, 208). Respect for others implies the way in which something connected with the other is regarded, understood, or interpreted. When we respect something in the other, we heed its call and acknowledge its claim to our attention (Dillon 2007, 203). People, who have respect for themselves, expect and require that others treat them with respect, consideration, and have regard for their feelings, wishes and individual opinions. (DeLellis 2000, 43.)

The manifestation of respect in the earlier literature is shown to be demonstrated through respect for others (DeLellis 2000) and also addresses and reflects on professional and ethical values in nursing interactions (Browne 1993, Gallagher 2007). The manifestations of respect in the earlier literature is described next by considering the dimensions (Dillon 1992) and the orientations (Browne 1993, Gallagher 2004) of respect for others, as well as theoretical and operational definitions of respect. The dimensions of respect for others include respect that is commonly shown and defines the attributes of its manifestation; while the orientations of respect for others describes the qualities required in the manifestation of respect. Both the dimensions and the orientations have a behavioural viewpoint which emphasises respect as an active value in nursing care (Gallagher 2007). The theoretical definitions of respect analyse respect in some of nursing theories, and operational definitions of respect on its measurable possibilities.

Dimensions of respect for others

The dimensions of respect for others, described by Dillon (1992), consists of the perceptional, dialogical, and behavioural dimensions (Table 3.). These three dimensions are important to understand when analysing respect between people. The dimensions of respect for others create the basis for the manifestations of respect in this study.

The first dimension of respect for others is the perceptional dimension. The perceptional dimension is based on attention, it is an intensely focused perception, and is central to the manifestation of respect: we respect something by paying careful attention to it (Dillon 1992, 108, Dillon 2007, 203). Respect as careful attention

concentrates on individuals as they are (not what they are) – ordinary and imperfect, and it values them in this light. In acknowledging human limitations, imperfections, and continual constructs, respect also comprises of the acceptance of frailty, patience, lenience, and responsiveness to other's needs. (Dillon 1992, 121.)

The second dimension of respect for others is the dialogical dimension; the way in which a person is related to and connected with others (Dillon 2007, 210). Respect as dialogical dimension requires reflective consideration. Respect involves a certain way of perceiving the subject and the way of recognizing their value, regarding them as important and worth taking seriously (Dillon 1992, 108). By recognising the value of the subject this leads to having and acting from certain positive attitudes, for example attitudes of cherishing, venerating, or appreciating (Dillon 1992, 109). Cherishing is a core attitude and a form of respect that involves profoundness of feeling, treasuring, warm regard, and solicitous concern. As an affectively rich responsiveness to others, cherishing provides the basis for an active engagement with others that respect for them involves. (Dillon 1992, 120.)

The third dimension of respect for others is its behavioural dimension which implies being involved, relating to, or empathising. To respect someone is to treat them in a certain manner or to act in ways that involve regarding them as calling for more than our attention, and as being able to make claims on our behaviour (Dillon 1992, 109, Dillon 2007, 204). There are several ways to show respect for someone: by showing consideration for them or taking them into account, by keeping our distance from them and giving them room, by praising, honouring, or revering them, by obeying or abiding by them, by avoiding them, by protecting and being careful with them (Dillon 1992, 109). Respect involves believing that there is something about the subject that makes it worthy of attention and actions. Our reason for respect is that the subject calls for that kind of response. (Dillon 1992,109.)

Table 3. The dimensions of respect for others: attributes, and manifestations (according to Dillon 1992, 2018).

Dimension	Attribute	Manifestation
Perceptional (attentiveness)	Intensely focused, observant attention to the other.	Showing interest in the other. Taking the views of the other seriously.
Dialogical (sensitiveness)	Active engagement with the other.	Considering and recognising the value of the other.
Behavioral (responsiveness)	Thoughtful response.	Attending and acting in appropriate ways.

Respect manifests itself in the form of observant attention, active engagement, and thoughtful response to the other.

Orientations of respect for others

The orientations of respect for others consist of qualities required for the manifestation of respect in nursing care (Table 4.). Respect as a fundamental value in nursing care is expressed through attitudinal, cognitive, and behavioural orientations toward every patient. These expressions of respect are indications of the ethical values held as regards human dignity, worthiness, uniqueness, and self-determination due to individuals; these values require unconditional acknowledgement, preservation, and engagement (Browne 1993, 1995, 1997, Gallagher 1997). The orientations of respect function together as a synergy and are part of the strategy to achieve a deeper understanding of the patients' perspective (Jonasson et al. 2010, Thompson et al. 2011).

The attitudinal orientation of respect for others is composed of having a caring attitude (Browne 1997, Gallagher 2007, Gallagher et al. 2008). Respect as an attitudinal orientation is expressed through caring and acceptance and protecting and promoting the values important to the other (Browne 1995, 1997, Gallagher 2004, Gallagher et al. 2008). To be conscious of one's own attitudes and their manifestations in verbal and nonverbal communication is essential in respectful relationships, as well as the desire to critically evaluate them if necessary (Browne 1995, 1997, Gallagher et al. 2008).

The cognitive orientation of respect for others consists of having knowledge of ethical principles and theories and the skills to adopt and adapt them in practice (Browne 1993, Gallagher 2007). Respect as a cognitive orientation maintains patient-centred attributes such as presence, reassurance, and honouring choices (DeHart et al. 2009, Ciemins et al. 2015), and promoting professional interpersonal communication strategies such as building rapport, reducing conflict, establishing safety, and engaging patients in their own care (Finch 2006, DeHart et al 2009).

The behavioral orientation of respect for others is composed of the will and intention to provide caring actions by operating positively according to ethical values (Browne 1993, Gallagher 2007). Respect as a behavioral orientation is expressed through humility and sensitivity (Finch 2006, Robichaud et al. 2006, Person & Finch 2009, Medvene & Lann-Wolcott 2010), verbal interactions and nonverbal responses (Heiselman & Noelker 1991, Finch 2006, Robichaud et al. 2006, Person & Finch 2009, Jonasson & Berterö 2012).

Table 4. The orientations of respect for others: qualities, and manifestations (according to Browne 1993 and Gallagher 2007).

Orientation	Quality	Manifestation
Attitudinal	Having a caring attitude.	Expressing care and acceptance. Protecting and promoting the other's values.
Cognitive	Having knowledge of ethical and professional values and the skills to adopt and adapt them in practice.	Maintaining patient-centred attributes like presence, reassurance, and honouring choices. Promoting professional interpersonal communication strategies.
Behavioral	Having the will and intention to provide caring actions by operating positively according to ethical values.	Expressing humility and sensitivity. Interacting verbally and nonverbally responsively.

The manifestation of respect in nursing care requires caring attitudes and behaviours to be reflected in ethical knowledge and professional skills.

Theoretical and operational definitions of respect

Theoretical definitions concerning respect for patients are linked particularly in person-centred nursing care (Dewin 2004, Greenberg 2004, McCormack & McCance 2006, Abley 2012) and relationships between patients and professionals where the patient is seen more as an active participant than as a passive recipient of care, advice, and instruction (Leino-Kilpi 1990, Peplau 1997, Gastmans 1999, Suhonen 2002, D'Antonio et al. 2014). Furthermore, in one of the main nursing theories about interpersonal relationships (Peplau 1952/1968) the progress of the relationship requires maturity in both the patients and nurses. Although, respect does not especially emerge in this theory it is there as a presupposition. Caring for patients almost always includes some action, such as administering to the patient or being with the patient (Watson 2008, Brilowski & Wendler 2005). These actions originate from the carer's perception of another person's needs, and result in the motivation to act to meet those needs (Brilowski & Wendler 2005).

Respect, as shown in the being of nurses and when doing things for patients can be found most clearly described in the nursing theory of Virginia Henderson (1966) and in the caring theory of Kristen Swanson (1991). The Need Theory of Henderson (1966) categorises nursing activities into 14 components based on human needs. The nurses' role is to work with patients and to do things for them with the goal of helping them to become as independent as possible (Henderson 1966). The Middle Range Theory of Caring by Swanson (1991) is based on five caring processes: knowing, being with, doing for, enabling, and maintaining beliefs. Being with, according to

Swanson (1991) is being emotionally present for the other, while doing something for is doing for the other what (s)he would do for them self if it were at all possible.

Operational definitions of respect make respect visible in nursing care and make it possible to perceive the respect. (Browne 1993). Browne (1993) suggests several actions indicative of respect which may be used in operational definitions: non-verbal messages (e.g. eye contact, facial expression, sensitive use of touch), verbal messages (e.g. tone of voice, expressions of honesty and acceptance), and nursing actions aimed at protecting patients' privacy and sense of modesty, allowing patients to make choices concerning their care, and explaining procedures fully before carrying them out. However, operationalising an abstract and multidimensional concept of respect can be difficult because it will be evaluated in terms of what it means to the individual (Browne 1993, 1997; DiBartolo 2006, Gallagher et al. 2008).

Respect has been explored using surveys and instruments, and by investigating e.g. the quality of nursing care (Leino-Kilpi 1992, Buzgova & Ivanova 2011, Aboumatar et al. 2015), satisfaction with nursing care (Suhonen et al. 2007, Kahn et al. 2015) or individualised care (Suhonen et al. 2007, Suhonen et al. 2012). Respect in these instruments has mainly been explored by asking one overarching question: 'Have you been treated with respect?' Moreover, surveys regarding respect have been investigated in association with other concepts, like kindness (Thompson et al. 2011) and dignity (Aboumatar et al. 2015). However, what patients consider should be included in respect has rarely been investigated. One subscale of the Caring Behaviours Inventory (CBI-24, Wolf et al. 2003) was found to measure Respectful Deference to Others (CBI-RDO); this inventory was used in this study as a criterion instrument. No existing single instrument for the measurement of respect as perceived by patients can be found in the literature review of this study. Earlier literature has emphasised that respect as a single phenomena of nursing care should be operationalised so as to obtain a better understanding of the concept and its manifestations in nursing care (Duffy et al. 2007, Aboumatar et al. 2015). In order to make operational definitions of respect in nursing care, the elements of respect must be identified as they are perceived by patients.

Respect in nursing care is linked to relationships between patients and professionals and can be perceived in nurses' beings and the way in which they do things for their patients. Respect as shown by nurses in their being and doing for patients is related to nurses' verbal and nonverbal messages and nursing actions aiming to protect ethical values during patient care.

2.3 Conceptual basis of respect in this study

The conceptual basis of respect in this study was constructed by summarising the analysis of the concept of respect in sections 2.1 and 2.2.

The conceptual basis of respect in this study is focused on patients' fundamental right to be cared for with respect and nurses' professional obligation to show respect in the delivery of ethical high-quality care. Respect is not something that has to be earned, and it should be conveyed even if it is not returned.

In the light of the dictionary definitions, the origin of the concept of respect seems to have come from expressions of esteem and regard, and treatment concordant with duties and obligations. Although respect is related to duties and obligations, it seems to be a pleasant and unforced responsibility expressing conformity, harmony, and flexibility.

Respect manifests itself in the form of observant attention, active engagement, and thoughtful response to the other. The manifestation of respect in nursing care requires caring attitudes and behaviours to be reflected in ethical knowledge and professional skills.

Respect in nursing care is linked to relationships between patients and professionals and could be perceived in the being of nurses and in their administrating practices towards their patients. Respect in the being and doing of nurses is related to nurses' verbal and nonverbal messages and nursing actions aiming to protect ethical values during patient care.

The following definition of the conceptual basis of respect in this study was as follows: Respect is nurses' expression of the value of patients demonstrated through their verbal and nonverbal communication and actions.

In this study, special interest was placed on older patients' perceptions of respect in relationships between older patients and nurses. Older patients were selected because based on their longer life and life experiences they may have valuable information as regards respect and its manifestation. Further, fragility following health problems and hospital care at a later age in life often result in special needs which must be taken into consideration in older patients' care. Responses to these needs also reflect the extent to which a caring culture is present in nursing care of older patients. To analyse respect in nursing care from the point of view of older patients, the empirical studies on respect will be reviewed in the next chapter.

3 Review of Empirical Studies on Respect in the Nursing Care of Older Patients

This review is presented as a summary phase in which to aggregate and amalgamate earlier literature reviews made in different phases of this study (Papers I-IV), and to strengthen the theoretical basis for the respect nurses demonstrate in their being and doing for patients that has been developed in this study. The purpose of this review is to identify elements of respect in nursing care as they could be perceived by older patients and factors associated with these elements. For this purpose, the literature search (3.1) and an overview of the studies (3.2) has been described following an examination of the empirical studies on respect in nursing care of older patients (3.3) and studies on factors associated with respect in the nursing care of older patients (3.4). Finally, a summary of the literature reviewed is presented and the needs for this study expressed (3.5).

3.1 Literature search

In this review, the database searches were carried out three times and a systematic search protocol was used (Figure 2). The database search concerning empirical studies on respect was carried out in four scientific databases: Medline (National Library of Medicine), CINAHL (Cumulative Index to Nursing and Allied Health Literature), PsycINFO (A world-class resource for abstracts and citations of behavioral and social science research), and Medic (Bibliographic Database Finnish) using the search terms respect, nursing care and older people with different combinations, and by using the search phrase: (respect OR respectful) NOT (respective OR respectively OR "with respect to") AND (nurse* OR nursing).

The citations produced by the searches are described in the Figure 2. No Finnish scientific articles concerning respect were found. The following inclusion criteria were used: each article had to be published in the English language and had to have an available abstract; be concerned with respect in nursing care focused on older patients (≥ 65 years); and report empirical data. The exclusion criteria used were theoretical articles and the articles where respect was not defined or described.

Retrieval of the articles to be included in the review was conducted in three steps. In the first step, all titles, and abstracts were screened using the inclusion criteria and all applicable empirical articles were included. In the second step, the full texts of

the included articles were analysed using the inclusion criteria by two researchers (JK & RS). As a result, 44 empirical articles remained for final consideration. All these articles (n=44) were carefully reviewed to form an understanding of respect and its associated factors in nursing care of older patients. The research articles and results concerning respect are presented in Appendix 1.

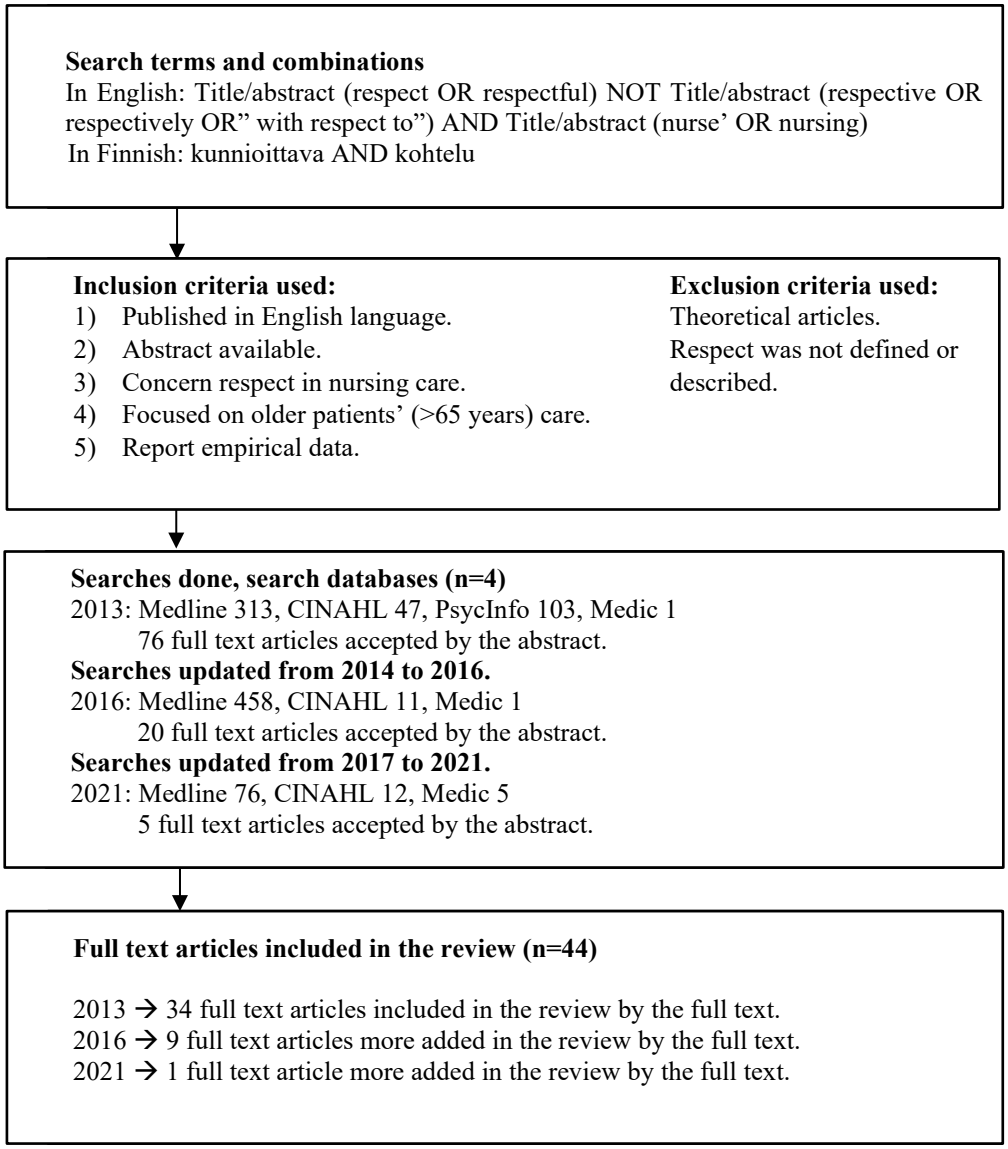

Figure 2. The search protocol for the literature review.

3.2 An overview of the studies

A narrative approach was used to obtain a better understanding of respect in the nursing care of older patients. A narrative approach strives to summarise, explain, and interpret the primary studies under review (Jones 2004, Mays et al. 2005). The aims of the review were to identify:

- the elements of respect in nursing care as perceived by older patients and
- the factors associated with respect in nursing care as perceived by older patients.

Respect in the nursing care of older patients was present in 44 empirical studies. Detailed information on the studies is described in Appendix 1. Most of the empirical studies have been carried out in the United States of America (n=16), Sweden (n=9) and Canada (n=6), few studies in Netherlands (n=2), Norway (n=2) and Taiwan (n=2), and single studies in Australia, Cyprus, Czech Republic, England, Thailand, Turkey, and United Kingdom. Most of the studies have been published between the years 2011- 2015 (n=19) and 2006- 2010 (n=14). The oldest (1991) and the newest (2017) study were both carried out in the USA.

The majority of the studies were set in long-term care settings (n=21) and hospital care settings (n=15). These studies have mainly considered the perspective of the older patients (n=23), the nursing staff (n=14) and the next of kin (n=9) with different combinations. Empirical studies from the point of view of the patients and their next of kin were rare (n=3). The age range of the participants was often broad in the studies reviewed, and older patients, aged 65 and over, were often a small part of a larger patient group. Most of the studies had a qualitative inquiry (n=28), while the others were non-experimental studies and had a descriptive (n=4) or a descriptive and correlational design (n=6). Three of the studies had both qualitative inquiry and non-experimental design (n=3), and three of the studies were interventions (n=3). None of the studies were experimental. (Appendix 2.).

The data collection methods used were mainly semi-structured interviews (n=21), questionnaires (n=11) and combinations of these methods (n=4). Three of the studies used observations (n=3) and focus groups (n=3) as the data collection method. One study (n=1) was a combination of three different methods, while one (n=1) used videos. The qualitative analysis methods predominantly used were content analysis (n=9), thematic analysis (n=7), grounded theory analysis (n=5) and phenomenological analysis (n=5). Qualitative software (Atlas.ti, NUDIST, NVivo 7) was used in four studies (n=4) while critical feminist theory (n=1), ethnography (n=1) and interpretative description (n=1) were each used once. Different statistical analysis was used in the non-experimental studies (n=15). Both qualitative and statistical analysis were used in four studies (Heiselman & Noelker 1991, Finch 2006, Evers et al. 2011, and Periyakoil et al. 2013). (Table 5.)

Table 5. Data collection methods and analysis used in the studies reviewed (n=44).

Data collection method	Reference
Semi-structured interview (including open-ended questions /interview guide)	Bertero & Ek 1993, Cooper & Mitchell 2004, Lee-Hsieh & Turton 2004, Nåden & Eriksson 2004, Smith 2005, Robichaud et al. 2006, Hellström & Sarvimäki 2007, Kvåle & Bondevik 2008, DeHart et al. 2009, Jonasson et al. 2010, Medvene & Lann-Wolcott 2010, Chung 2013, Holmberg et al. 2012, Song et al. 2012, Bolz et al. 2013, Hwang et al. 2013, Oosterveld-Vlug et al. 2013, Oosterveld-Vlug et al. 2014, Beach et al. 2015, Ciemins et al. 2015, Emsfors et al. 2017.
Questionnaire	Ryan et al. 1994, Brunton & Beaman 2000, Williams 2006, Can et al. 2008, Arcand et al. 2008, Buzgova & Ivanova 2011, Ström et al. 2011, Thompson et al. 2011, Williams & Herman 2011, Papastavrou et al. 2012, Bowersox et al. 2013.
Combination of semi-structured interview and questionnaire	Heiselman & Noelker 1991, Finch 2006, Evers et al. 2011, Periaykoil et al. 2013.
Observation	Berg et al. 2007, Bourbonnais & Ducharme 2010.
Combination of observation and interview	Jonasson & Berterö 2012.
Focus group	Calvin et al. 2007.
Combination of focus group and interview	Bayer et al. 2005, Percival & Johnson 2013.
Combination of interview, focus group and observation	Hoontrakul et al. 2008.
Video	Hansebo & Kihlgren 2002.
Qualitative data analysis	
Content analysis	Heiselman & Noelker 1991, Bertero & Ek 1993, Smith 2005, Hellström & Sarvimäki 2007, Hoontrakul et al. 2008, Medvene & Lann-Wolcott 2010, Bolz et al. 2013, Hwang et al. 2013, Percival & Johnson 2013.
Thematic analysis	Cooper & Mitchell 2004, Bayer et al. 2005, Calvin et al. 2007, Evers et al. 2011, Oosterveld-Vlug et al. 2013, Oosterveld-Vlug et al. 2014, Beach et al. 2015.
Grounded theory analysis	Lee-Hsieh & Turton 2004, Chung 2012, Jonasson et al. 2010, Jonasson & Berterö 2012, Song et al. 2012.
Phenomenological analysis	Hansebo & Kihlgren 2002, Nåden & Eriksson 2004, Finch 2006, Berg et al. 2007, Kvåle & Bondevik 2008.
Qualitative software (Atlas.ti, NUDIST, NVivo 7)	Robichaud et al. 2006, DeHart et al. 2009, Periaykoil et al. 2013, Ciemins et al. 2015.
Critical incident technique (CIT)	Emsfors et al. 2017.
Ethnographic analysis	Bourbonnais & Ducharme 2010.
Interpretative description analysis	Holmberg et al. 2012.
Statistical data analysis	Heiselman & Noelker 1991, Ryan et al. 1994, Brunton & Beaman 2000, Finch 2006, Williams 2006, Can et al. 2008, Arcand et al. 2008, Buzgova & Ivanova 2011, Evers et al. 2011, Ström et al. 2011, Thompson et al. 2011, Williams & Herman 2011, Papastavrou et al. 2012, Bowersox et al. 2013, Periaykoil et al. 2013.

Four empirical studies with the focus of the study on respect, were found in this literature review (Table 6). These studies addressed respect together with dignity (Beach et al. 2015), human presence (Papastavrou et al. 2012), kindness (Thompson et al. 2011), and mutual respect (Heiselman & Noelker 1991). In these studies, respect was felt when nurses cared for their patients as a family member or a friend, as an individual, and as an equal of the nurses themselves. The specific behaviours that demonstrated respect for patients were the nurses' way of actively listening to their patients and being responsive, their ability to give honest information with understandable explanations, and their good bedside manners which demonstrated compassion and concern. An important finding by Beach et al. (2015) was that respect is more than the sum of any particular behaviours.

The other focuses of the studies concerning respect in the nursing care of older patients were the patient-nurse interactions and communications, the ethical values and issues in nursing care, the competence of the health care professional, the quality of nursing care, satisfaction with the nursing care, and the quality of life.

Table 6. Focus of respect in the studies reviewed (n=44).

Focus of the studies	References
Respect n=4	Heiselman & Noelker 1991, Thompson et al. 2011, Papastavrou et al. 2012, Beach et al. 2015
Patient-nurse interaction and communication n=13	Ryan et al. 1994, Brunton & Beaman 2000, Hansebo & Kihlgren 2002, Lee-Hsieh & Turton 2004, Finch 2006, Williams 2006, Berg et al. 2007, Calvin et al. 2007, Bourbonnais & Ducharme 2010, Medvene & Lann-Wolcott 2010, Williams & Herman 2011, Song et al. 2012, Emsfors et al. 2017.
Ethical values and issues in nursing care n=13	Nåden & Eriksson 2004, Bayer et al. 2005, Smith 2005, Hellström & Sarvimäki 2007, Jonasson et al. 2010, Buzgova & Ivanova 2011, Evers et al. 2011, Holmberg et al. 2012, Jonasson & Berterö 2012, Hwang et al. 2013, Oosterveld-Vlug et al. 2013, Periyakol et al. 2013, Oosterveld-Vlug et al. 2014.
Quality of nursing care n=6	Cooper & Mitchell 2004, Hoontrakul et al. 2008, Kvåle & Bondevik 2008, Chung 2012, Bolz et al. 2013, Percival & Johnson 2013.
Satisfaction with nursing care n=5	Can et al. 2008, Arcand et al. 2008, Ström et al. 2011, Bowersox et al. 2013, Ciemins et al. 2015.
Quality of life n=2	Bertero & Ek 1993, Robichaud et al. 2006.
Health care professionals' competence n=1	DeHart et al. 2009.

3.3 Respect in nursing care of older patients

To find out the elements of respect in nursing care as perceived by older patients, a synthesis of the studies (n=44) is presented using three main themes: respect as shown in the being of nurses, respect as shown in the doing of nurses, and disrespect as shown in the being and doing of nurses. (Table 7.)

Table 7. The elements of respect and disrespect in nurses' being and doing.

THEMES	REFERENCES
Respect as shown in the being of nurses	
Essence	
Being kind and polite.	Heiselman & Noelker 1991, Hansebo & Kihlgren 2002, Finch 2006, Calvin et al. 2007, Hoontrakul et al. 2008, Medvene & Lann-Wolcott 2010, Song et al. 2011, Thompson et al. 2011, Williams & Herman 2011, Chung et al. 2012, Song et al. 2012, Percival & Johanson 2013, Beach et al. 2015, Emsfors et al. 2017.
Being attentive, sensitive, and responsive.	Heiselman & Noelker 1991, Hansebo & Kihlgren 2002, Smith 2005, Kvåle & Bondevik 2008, Song et al. 2011.
Commitment	
Being motivated and showing willingness to care for older patients.	Heiselman & Noelker 1991, Bertero & Ek 1993, Finch 2006, Thompson et al. 2011, Beach et al. 2015, Emsfors et al. 2017.
Being proficient and having knowledge of ethical and professional values and good communication skills.	Ryan et al. 1994, Brunton & Beaman 2000, Hansebo & Kihlgren 2002, Lee-Hsieh & Turton 2004, Nåden & Eriksson 2004, Bayer et al. 2005, Smith 2005, Finch 2006, Williams 2006, Berg et al. 2007, Calvin et al. 2007, Hellström & Sarvimäki 2007, DeHart et al. 2009, Bourbonnais & Ducharme 2010, Jonasson et al. 2010, Medvene & Lann-Wolcott 2010,Buzgova & Ivanova 2011, Evers et al. 2011, Williams & Herman 2011, Holmberg et al. 2012, Jonasson & Berterö 2012, Song et al. 2012, Hwang et al. 2013, Oosterveld-Vlug et al. 2013, 2014, Periyakol et al. 2013, Ciemins et al. 2015.
Being suited to caring work: being genuine and responsible.	Nåden & Eriksson 2004, Berg et al. 2007, Song et al. 2011, Beach et al. 2015.
Respect as shown in the doing of nurses	
Accepting	
Valuing patients as unique individuals.	Hansebo & Kihlgren 2002, Lee-Hsieh & Turton 2004, Finch 2006, Kvåle & Bondevik 2008, Holmberg et al 2012, Beach et al. 2015.
Demonstrating kind and sensitive verbal and nonverbal expressions.	Hansebo Kihlgren 2002, Hoontrakul et al. 2008, Jonasson et al. 2010, Periyakoil et al. 2013.
Considering individual habits and cultural customs.	Lee-Hsieh & Turton 2004, Percival & Johanson 2013. Song et al. 2012.
Treating patients as equals.	Bertero & Ek 1993, Smith 2005, Bowersox et al. 2013, Beach et al 2015.

THEMES	REFERENCES
Listening / Interacting	
Showing interest in patients' views.	Bertero & Ek 1993, Hansebo & Kihlgren 2002, Nåden & Eriksson 2004, Finch 2006, Calvin 2007, Kvåle & Bondevik 2008, Jonasson et al. 2010, Holmberg et al. 2012, Bowersox et al. 2013, Periyakoil et al. 2013.
Listening carefully to patients.	Calvin et al. 2007, Kvåle & Bondevik 2008, Jonasson et al. 2010, Holmberg et al. 2012, Bowersox et al. 2013, Periyakoil et al. 2013, Beach et al. 2015.
Taking seriously everything discussed.	Berg et al. 2007, Kvåle & Bondevik 2008, Song et al. 2012, Bowersox et al. 2013, Oosterveld-Vlug et al. 2013.
Asking questions to achieve a deeper understanding.	Nåden & Eriksson 2004, Finch 2006, Hoontrakul et al. 2008, Kvåle & Bondevik 2008, Jonasson & Berterö 2012, Periyakoil et al. 2013.
Encouraging	
Showing positive concern.	Bertero & Ek 1993, Finch 2006, Berg et al. 2007, Jonasson et al. 2010, Medvene & Lann-Wolcott 2010, Holmberg et al. 2012, Emsfors et al. 2017.
Supporting patients' individual capacities.	Hansebo & Kihlgren 2002, Cooper & Mitchell 2004, Robichaud et al. 2006, Jonasson & Berterö 2012, Bolz et al. 2013, Hwang et al. 2013, Periyakoil et al. 2013, Ciemins et al. 2015.
Promoting patients' participation and allowing the possibility to make choices.	Berg et al. 2007, Hellström & Sarvimäki 2007, Jonasson & Berterö 2012, Hwang et al. 2013.
Maintaining patients' hope.	Berg et al. 2007, Kvåle & Bondevik 2008, Jonasson & Berterö 2010.
Maintaining information sharing.	Hansebo & Kihlgren 2002, Thompson et al. 2011, Chung 2012, Song et al. 2012, Bowersox et al. 2013, Percival & Johnsson 2013, Beach et al. 2015.
Nurturing	
Being available when needed.	Bertero & Ek 1993, Cooper & Mitchel 2004, Bourbonnaise & Ducharme 2010, Medvene & Lann-Wolcott 2010, Periyakoil et al. 2013.
Acknowledging, asking, meeting, and responding to patients' various care needs.	Heiselman & Noelker 1991, Hansebo & Kihlgren 2002, Smith 2005, Robichaud et al. 2006, Can et al. 2008, Kvåle & Bondevik 2008, Bourbonnais & Ducharme 2010, Jonasson et al. 2010, Thompson et al. 2011, Papastavrou et al. 2012, Oosterveld-Vlug et al. 2013, Periyakoil et al. 2013, Beach et al. 2015.
Creating a safe, caring atmosphere.	Finch 2006, Berg et al. 2007, Jonasson et al. 2010, Medvene & Lann-Wolcott 2010, Bolz et al. 2013, Hwang et al. 2013.
Disrespect as shown in the being of nurses	
Essence	
Being stressed, dominant or irritated, short in tone or unwilling to discuss treatment alternatives.	Emsfors et al. 2017.

THEMES	REFERENCES
Being impatient and rude.	Buzgova & Ivanova 2011.
Being cold, distant, and impersonal.	Heiselman & Noelker 1991, Papastavrou et al. 2012.
Disrespect as shown in the doing of nurses	
Ignoring	
Disregarding opinions.	Bayer et al. 2005, Buzgova & Ivanova 2011.
Denying help.	Hellström & Sarvimäki 2007.
Making patients wait a long time.	Hellström & Sarvimäki 2007.
Underestimating	
Baby talking speech, infantilising speech.	Heiselman & Noelker 1991, Ryan et al. 1994, Williams 2006, Buzgova & Ivanova 2011, Williams & Herman 2011.
Controlling	
Dominating, bossing, or commanding	Williams 2006, Buzgova & Ivanova 2011.
Humiliating	
Attempted slapping.	Buzgova & Ivanova 2011.
Using physical restraints.	

Respect as shown in the being of nurses

Respect in the being of nurses was perceived as the essence of nurses and illustrated their commitment to the care of their patients. Respect as regards the **essence** of a nurse was visible when they were kind and polite; attentive, sensitive, and responsive. Kind and polite nurses were easy to approach, smiled and were cheerful (Finch 2006, Robichaud et al. 2006, Kvåle & Bondevik 2008, Chung 2012), addressed patients properly (Lee-Hsieh & Turton 2004), gave compliments (Medvene & Lann-Wolcott et al. 2010) and asked for approval before acting (Hansebo & Kihlgren 2002, Lee-Hsieh & Turton 2004, Song et al. 2011). Attentive, sensitive, and responsive nurses saw a situation from the patients' point of view (Hansebo & Kihlgren 2002, Smith 2005, Bourbonnaise & Ducharme 2010), supported patients' capacities and were quick to provide help when needed (Hansebo & Kihlgren 2002, Percival & Johnson 2013).

Respect as regards nurses' **commitment** was perceived when nurses were motivated, proficient, and suited to the profession of caring for older patients. Respect as regards nurses' motivation was apparent when they showed interest in older patients as human beings and conveyed a willingness to care for them (e.g. Finch 2006, Thompson et al. 2011). Respect was observable in nurses who had knowledge of ethical and professional values and the skills to adopt and adapt them in nursing care (DeHart et al. 2009, Ciemins et al. 2015). Respect demonstrated in nurses' proficiency was visible in good verbal and nonverbal communication skills and competency at building rapport and mutual understanding with their patients

(DeHart et al. 2009, Thompson et al. 2011, Jonasson & Berterö 2012). Genuineness in interactions and taking responsibility for understanding the patient's specific situation (Berg et al. 2007, Song et al. 2011) were essential demonstrations of respect expressing a nurse's suitability for caring work.

Respect as shown in the doing of nurses

Respect in the doing of nurses was perceived in the activities of nurses that conveyed accepting, listening, encouraging, and nurturing in care provision. Respect as **accepting** was perceived in nurses' ways of valuing patients as unique individuals (e.g. Hansebo & Kihlgren 2002, Holmberg et al 2012, Bolz et al. 2013, Beach et al. 2015) and demonstrating kind and sensitive verbal and nonverbal expressions in all interactions with their patients (e.g. Hoontrakul et al. 2008, Jonasson et al. 2010, Periyakoil et al. 2013). Considering patients' individual habits and cultural customs (e.g. Lee-Hsieh & Turton 2004, Kvåle & Bondevik 2008, Percival & Johanson 2013) and treating them as equals (e.g. Bertero & Ek 1993, Smith 2005, Bowersox et al. 2013, Beach et al 2015) were also central to respect perceived in nurses' activities.

Respect as shown by nurses' **listening** was perceived when nurses expressed interest in patients' views (e.g. Bertero & Ek 1993, Nåden & Eriksson 2004, Finch 2006, Calvin 2007, Jonasson et al. 2010, Holmberg et al. 2012, Periyakoil et al. 2013) and listened carefully to their patients (e.g. Kvåle & Bondevik 2008, Bowersox et al. 2013, Beach et al. 2015). Nurses' activities that took seriously everything discussed (e.g. Berg et al. 2007, Kvåle & Bondevik 2008, Song et al. 2012) and asking questions to achieve a deeper understanding (e.g. Nåden & Eriksson 2004, Finch 2006, Hoontrakul et al. 2008, Jonasson & Berterö 2012) were also perceived as central in respect experiences.

Respect was also shown through nurses' **encouraging** patients; by giving positive regard (e.g. Bertero & Ek 1993, Finch 2006, Jonasson et al. 2010, Medvene & Lann-Wolcott 2010), supporting patients' individual capacities (e.g. Cooper & Mitchell 2004, Robichaud et al. 2006, Bolz et al. 2013, Hwang et al. 2013, Periyakoil et al. 2013, Ciemins et al. 2015), promoting their participation and giving possibilities to make choices (e.g. Berg et al. 2007, Hellström & Sarvimäki 2007, Jonasson & Berterö 2012), and working to maintain patients' hope (Berg et al. 2007, Kvåle & Bondevik 2008, Jonasson & Berterö 2010) were all felt to offer respect to the patients. Moreover, maintaining information sharing was felt to be an important expression of respect in nurses' doing (Hansebo & Kihlgren 2002, Thompson et al. 2011, Chung 2012, Song et al. 2012, Bowersox et al. 2013, Percival & Johnsson 2013).

Respect shown in nurses' **nurturing** was apparent in nurses' always being available when needed (Bertero & Ek 1993, Cooper & Mitchel 2004, Bourbonnaise

& Ducharme 2010, Medvene & Lann-Wolcott 2010, Periyakoil et al. 2013), and acknowledging, asking, meeting, and responding to patients' various care needs and hopes (Robichaud et al. 2006, Bourbonnais & Ducharme 2010, Thompson et al. 2011, Jonasson & Berterö 2012), and by caring for them with patience and sympathy in order to and create a safe and caring atmosphere (e.g. Finch 2006, Berg et al. 2007, Jonasson et al. 2010, Medvene & Lann-Wolcott 2010).

Disrespect as shown in the being and doing of nurses

Respect can be approach from the opposite point of view, disrespect in nurses' being or doing. Disrespect was often related to staff attitudes and ageism, and to patients' diminishes health status, e.g. dementia or aphasia (Buzgova & Ivanova 2011, Papastavrou et al. 2012). Disrespect in a nurses' **essence** was apparent when nurses were stressed, dominant or irritated, short in tone or unwilling to discuss treatment alternatives (Emsfors et al. 2017), impatient or rude (Buzgova & Ivanova 2011) and when their expressions were cold, distant, and impersonal (Heiselman & Noelker 1991, Papastavrou et al. 2012).

Respect as shown in nurses' doing was lacking when patients were **ignored** (Bayer et al. 2005, Hellström & Sarvimäki 2007, Buzgova & Ivanova 2011), **underestimated** (Heiselman & Noelker 1991, Ryan et al. 1994, Williams 2006, Williams & Herman 2011) or **controlled** (Williams 2006). Ignoring was felt when older patients' opinions were not asked for or valued (Bayer et al. 2005, Buzgova & Ivanova 2011), when they were asked for help but were denied it or they were made to wait for a long time (Hellström & Sarvimäki 2007). Baby talk speech (Heiselman & Noelker 1991, Ryan et al. 1994) and infantilizing speech were felt disrespectfully (Williams 2006, Williams & Herman 2011), as well as messages conveying higher levels of control (e.g. dominating, controlling, bossy and directive) (Williams 2006).

Summary of respect shown in nurses' being and doing

In summary, respect shown in nurses' being and doing created a caring and responsive relationship, a type of commitment to and involvement with a patient. Respect enables patients to feel seen and heard, valued, and cared for. Respect shown in nurses' being and doing establishes trust and confidence in a caring relationship by increasing patients' self-worth and self-confidence, and by enhancing their feeling of being safe and their sense of well-being. Moreover, respect empowered patients to live independently, a life peculiar for themselves.

3.4 Factors associated with respect in nursing care of older patients

Three factors were identified as being associated with respect in nursing care as perceived by older patients: sociodemographic characteristics, health-related quality of life and the care satisfaction of older patients (Table 8.). The following paragraphs will describe these factors in detail.

Table 8. Factors associated with respect in nursing care of older patients.

Patient-related factor	References
Sociodemographic characteristics	Thompson et al. 2011.
Health-related quality of life	Bertero & Ek 1993, Robichaud et al. 2006, Hellström & Sarvimäki 2007, Kvåle & Bondevik 2008, DeHart et al. 2009, Buzgova & Ivanova 2011, Oosterveld-Vlug et al. 2014.
Satisfaction with nursing care	Arcand et al. 2008, Can et al. 2008, DeHart et al. 2009, Buzgova & Ivanova 2011, Ström et al. 2011, Bowersox et al. 2013, Ciemins et al. 2015.

Respect in relation to older patients' sociodemographic characteristics

Respect in relation to older patients' sociodemographic characteristics is contradictory. In the study by Thompson et al. (2011), male relatives were more likely than female relatives to indicate that the resident was not always treated with respect. However, no research could not be found to corroborate this finding.

Respect in relation to health health-related quality of life

Respect in relation to health-related quality of life is two fold. To be treated with respect could have an impact on experiences of health-related quality of life and vice versa experiences of health-related quality of life could have an impact on perceived respect (Berterö & Ek 1993, Robichaud et al. 2006). This respect includes the importance of being treated as an individual, not becoming incapacitated as a human being, and being accepted as a person, responsible for oneself and one's own decisions (Bertero & Ek 1993). Older patients' needs, interests, habits, and capacities were defined as the most important respect-related aspects for health-related quality of life experiences (Robichaud et al. 2006).

Patients' health status was related to their perceptions of respect. For example, when respect was not perceived patients often experienced restlessness, agitation or confusion. (Thompson et al. 2011.) Moreover, patients who perceived themselves as

a burden to others often believe that others consider them no longer worthy of respect (Hellström & Sarvimäki 2007, Kvåle & Bondevik 2008, Buzgova & Ivanova 2011). Illness-related conditions and functional incapacity have been found to threaten patients' personal dignity and their individual self, whereas by treating patients with respect these threats could be prevented (DeHart et al. 2009, Oosterveld-Vlug et al. 2014).

Respect in relation to satisfaction with nursing care

Respect in relation to satisfaction with nursing care could be similarly two fold. Respect has been found an important factor in patients' assessments of satisfaction with nursing care (Arcand et al. 2008, Can et al. 2008, Ström et al. 2011, Ciemins et al. 2015). Respect-related factors associated with satisfaction with nursing care included kindness and sensitivity to patients' needs, and provision of comfort and emotional support (Arcand et al. 2008, Can et al. 2008, DeHart et al. 2009). Moreover, respect shown in the manner of listening carefully to patients, appreciating what they say and caring about them as individuals, promoted patients' satisfaction with nursing care (DeHart et al. 2009, Bowersox et al. 2013). On the other hand, dissatisfied patients may assess nursing care more critically than satisfied patients attributing dissatisfaction to personal characteristics or previous poor experiences of nursing care (DeHart et al. 2009, Budzova & Ivanova 2011).

The studies reviewed indicate there may be associations between patients' perceived respect in nursing care and their perceived health status and satisfaction with nursing care.

3.5 Summary of the empirical literature

In summary, respect shown in nurses' being and doing creates a caring and responsive relationship, and a type of commitment to and involvement with patients. Respect enabled patients to feel seen and heard, valued, and being cared for. Respect shown in nurses' being and doing established trust and confidence in a caring relationship by increasing patients' self-worth and self-confidence, and by enhancing their feeling of being safe and their sense of well-being. Moreover, respect empowered patients to live an independent life unique to them. Further, the studies reviewed indicate there may be associations between patients' perceived respect in nursing care and their perceived health status and satisfaction with nursing care.

Based on the literature reviewed, descriptions of respect in nursing care of older patients are very dispersed and the general view seems to be fragmented. Respect was especially present in empirical studies evaluating especially values and attitudes in nursing care and interactions and communication between patients and professionals. The findings indicate respect as a single phenomenon in nursing care has rarely been analysed.

Although empirical studies on respect in nursing care have considered older patients' point of views, the perceptions of patients aged 65 and over, were often a minor part of a larger patient group; this would indicate that patients' perceptions still need to be identified from the perspective of older patients.

No single instrument for the measurement of respect perceived by older patients could be found in the literature reviewed. By developing and testing an instrument measuring respect the concept will be made more visible in nursing care and allow possible needs to be found that will improve respect in nursing practice.

4 Aims of the Study

The purpose of this three-phased study (Figure 1) was to analyse respect in nursing care as perceived by older patients, and to develop and to test an instrument for its evaluation. In the first, conceptual phase, the aim was to define and describe respect in nursing care from older patients' point of view. In the second, instrumentation phase, the aim was to develop an instrument for the measurement of respect perceived by older patients. In the third, evaluation phase, the aim was to evaluate respect and its associated factors as perceived by older patients, using the instrument developed in the earlier phase. The goal was to deepen the understanding of respect in nursing care and to provide possibilities to measure it. The more specifically research questions (1–5) were as follows:

Phase I, Conceptual phase

1. How is respect for older patients in nursing care experienced by the older patients themselves and their next of kin? (Paper I, summary)
2. How is respect manifested in an older patient-nurse relationship? (Paper II, summary)

Phase II, Instrumentation phase

3. What are the elements of respect perceived by older patients in the care provided by nurses? (Paper III)

Phase III, Evaluation phase

4. To what extent do older patients perceive respect in the nursing care provided by nurses? (Papers III, IV)
5. What are the associations between respect perceived by older patients and their sociodemographic characteristics, perceived health, and satisfaction with nursing care? (Paper IV)

5 Materials and Methods

This three-phased study, including different approaches and designs, was conducted in the context of acute and long-term care settings among older patients in three urban areas in South-West Finland. The study was carried out between 2009 and 2020.

The main concern in Phase I was to define the concept of respect and to describe its manifestation in nursing care from the perspective of older patients (Papers I-II, summary). To achieve this, the narrative approach with individual open interviews was selected. The results of the first phase and the literature served as the structure and content for the operationalisation of the measurement of respect in Phase II (Paper III). In Phase III, the methodological approach with structured face-to-face interviews was selected to evaluate respect and its associated factors as perceived by of older patients (Papers III, IV).

The following chapters will present the designs, settings, samples, data collection methods and analysis used throughout the study (Table 9.).

Table 9. Designs, settings, samplings, data collection methods and analysis of the study.

Phase	Paper	Design	Setting	Sampling	Methods of data collection	Data analysis
I	I	Descriptive	Acute care	Purposive, Patients (n=10) Next of kin (n=10) *Data I*	Individual open interviews Literature review	Inductive content analysis
I	II	Descriptive, Narrative	Long-term care	Purposive, Patients (n=20) Next of kin (n=20) *Data II*	Individual open interviews Literature review	Inductive content analysis Construction of a typology
II	III	Methodological	Researchers on ethics and in older people care	Purposive, Professionals (n=10, n=5) *Data III*	Expert panels Item pools of ReSpect instrument Inductive reasoning	Expert analysis: relevance and clarity, 4-point scale
II	III	Descriptive, Correlational	Hospital care	Purposive, Patients (n=30) *Data IV*	Pilot Structured face-to-face interview ReSpect scale PSS, EQ-5D-5L	Statistical preliminary Cronbach α
III	III, IV	Descriptive, Cross-sectional, Correlational	Hospital care	Purposive, Patients (n=200) *Data V*	Structured face-to-face interview ReSpect scale PSS, EQ-5D-5L	Statistical Cronbach α, Inter-item, Item-total correlations, PCA

5.1 Designs, settings and sampling

In Phase I, a descriptive and narrative research design (Table 9.) (Denzin & Lincoln 2005, Moen 2006, Hsu & McCormack 2010) was used in acute (Data I) and long-term care settings (Data II) with older patients and their next of kin in order to define and describe respect as shown in nursing care from older patients' point of view (Papers I, II). A narrative approach was selected to discover the participants opinion on respect (Moen 2006). Older patients were chosen as the participants because they are one of the largest groups of patients being cared for in different care settings and their care might well reflect the extent to which respect in nursing care exists (Buzkova & Ivanova 2011, Hwang et al. 2013). Patients' next of kin are often in a central position when clarifying a patients' opinions about the care they are receiving (Hallström & Elander 2001, Bourbonnais & Ducharme 2010, Bridges et al. 2010, Jonasson et al. 2010), which was the reason for including the next of kin group in the study. (Papers I, II)

Purposeful sampling methods were used in both Data I and II so as to include participants capable of providing as many experiences and perceptions as possible and to obtain further insight into the type of respect being examined (Patton 2002). The older patients were chosen by the nursing staff and recruited by the researcher (JK), who conducted all the interviews in both data collects (Data I and II, n= 60). (Papers I, II)

Data I (n=20) consisted of older patients (n=10) cared for in an acute ward in one hospital in Southern Finland and one next of kin of each (n=10) chosen by the older patients themselves (Paper I). Data II (n=40) consisted of older dementia patients (n=20) receiving professional home care (n=10) and nursing home care (n=10) in three municipalities in Southern Finland, and one next of kin (n=20) named by the older patient. The interviewees (n=40) were selected from Finnish participants (N=304) in an EU-funded European research project, RightTimePlaceCare (RTPC-HEALTH-F3-2010-242153) which aims to improve dementia care for European Citizens (Verbeek et al. 2012). (Paper II)

The inclusion criteria for the patients in the study is presented in Table 10. Demographic data on the patients in the study is presented in Table 11. and on the next of kin in Table 12.

Table 10. Inclusion criteria of the patients of the study.

Criteria	Data I	Data II H*/NH**	Data IV	Data V
Aged 65 or older		X / X	X	X
Aged over 75 years	X			
Being cared for in an acute ward	X			
Able to communicate in Finnish	X	X / X	X	X
Having next of kin who frequently visited the hospital	X	X / X		
Oriented in time and place as assessed by nurses	X	X / X	X	X
Willing to participate voluntary in study	X	X / X	X	X
Had a formal diagnosis of dementia disease recorded in their medical record		X / X		
Had a mini-mental state examination (MMSE) score of 24 or lower***		X / X		
Lived in nursing home under one year but longer than three months		- / X		
Hospitalized for at least five days (including arrival and discharge days)			X	X

*H = home care, **NH = nursing home care, *** Mollow et al. 1991

In Phase II, a methodological design was used to operationalise respect as a measurement. Operational definitions of respect were created based on the analysis of the Phase I and two expert panels were used to evaluate the items. The participants of the expert panels (Data III: n=10 and n=5) were purposively selected experts in nursing ethics and in the field of older patients' nursing care. Older hospital patients were selected as the pilot group (Data IV, n=30) and the aim was to also test the ReSpect instrument later in a corresponding group on a larger scale. (Paper III)

In Phase III, a descriptive, cross-sectional, and correlational design was used within a hospital care setting, to evaluate respect and to test factors associated with its manifestation. Data V (n=196) consisted of older patients on eleven rehabilitation wards in two hospitals in Southern Finland. A hospital care setting was chosen because the need to maintain respectful behaviours and attitudes within hospital-based nursing care is an established requirement (Hallström & Elander 2001, Nåden & Eriksson 2004, Birrel et al. 2006, Kvåle & Bondevik 2008, Papastavrou et al. 2012, Bowersox et al. 2013), and these hospitals admitted the highest number of older patients in need of rehabilitation treatment within the examined caring area. The inclusion criteria and demographic data of the patients and next of kin are presented in Tables 10, 11, and 12. (Papers III, IV)

Table 11. Demographic data on older patients of the study.

Variable	Data I (n=10)	Data II (n=20)	Data IV Pilot (n=30)	Data V Main study (n=196)
Age (mean) / years	84	84	83	82
Range	76–92	69–97	68–98	65–100
Female (%)	7 (70)	16 (80)	19 (63)	131 (67)
Marital status (%)				
Unmarried	–	–	6 (20)	14 (7)
Married / Cohabitation	–	–	8 (27)	55 (28)
Divorced	–	–	5 (17)	23 (12)
Widow	–	–	11 (36)	104 (53)
Basic education (%)				
Primary school	–	–	4 (13)	174 (89)
Secondary school graduation	–	–	26 (87)	22 (11)
Professional education (%)				
No vocational	–	–	16 (53)	123 (63)
Vocational	–	–	13 (44)	60 (31)
University	–	–	1 (3)	13 (6)
Living situation (%)				
Alone	7 (70)	7 (35)	22 (73)	125 (64)
With next of kin	2 (20)	3 (15)	8 (27)	59 (30)
Nursing home	1 (10)	10 (50)	0 (0)	12 (6)
Chronic diseases (%)				
Hearth disease	–		17 (57)	92 (47)
Hypertension	–		17 (57)	92 (47)
Diabetes	–		2 (7)	46 (23)
Lung disease	–		5 (17)	42 (21)
Musculoskeletal disease	–		6 (20)	47 (24)
Memory disorder	–	20 (100)	0 (0)	5 (3)
Depression	–		0 (0)	21 (11)
Cancer	–		6 (20)	34 (17)
Other	–		9 (30)	35 (35)
MMSE–score** < 24 (range)		20		
Length of the care period, days	–	–	9	14
Range	–	–	5–23	5–120
Visits of next of kin's				
Yes / No	–	–	28 / 2	182 / 14
7 days a week (%)	–	–	11 (36)	98 (50)
Cared for in a room for (%)				
one patient	–	–	2 (7)	14 (7)
2–3 patients	–	–	8 (27)	76 (39)
4–6 patients	–	–	20 (67)	106 (54)

Table 12. Demographic data on next of kin of the study.

Variable	Data I (n=10)	Data II (n=20)
Age (mean) / years	–	61
Range		29–86
Female (%)	10 (100)	14 (70)
Marital status (%)		
Unmarried	–	1 (5)
Married / Cohabitation	–	14 (70)
Divorced	–	4 (20)
Widow	–	1 (5)
Relationship (%)		
spouse	2 (20)	3 (15)
child or grandchild	4 (40)	11 (55)
other	4 (40)	6 (30)

5.2 Data collection methods

In Phase I, individual open interviews were selected to gather information from older patients who may have had difficulties with reading and writing (Watson et al. 2008). Further, the interview method made it possible to obtain information about poorly investigated phenomena as well the opportunity to ask additional questions, seek clarifications and request more precise answers. The nature of the questions was as open as possible. The main question in the first interview study was:" What is respect in the care of older patients?", and in the second study:" What it is to be respected by nurses?" The main question was followed by questions that arose from participants' answers. The interview guide, made based on existing respect literature, ensured that the same questions were asked of all participants. The interview guide (Watson et al. 2008) was piloted by two older patients for both data indications of its usefulness and the applicability of the questions. The interviews carried out in a place chosen by the participants, and were tape recorded; the interviews took 20 minutes to 1.5 hours (mean 55 minutes). (Papers I, II)

In Phase II, two expert panels were conducted to review and critique the items in the instrument (DeVon et al. 2007, Rattray & Jones 2007) and to support the face, content, and construct validity. A pilot study was then conducted with older hospital patients. Researcher (JK) collected the data by individually interviewing older patients to obtain as much information as possible about the homogeneity, format, and instructions of the 23–items ReSpect Scale. (Paper III)

In Phase III, structured face–to–face interviews employing four instruments were used to collect the data. Individual interviews were selected to obtain

information from older patients who may have had visual or motoric difficulties using the self–report data collection systems (Peel & Wilson 2008). The patients were recruited with the support of nursing staff. The interviews were conducted by two researchers (JK/RH) using the same data collection procedure (Holloway & Wheeler 2002). The interviews took place in the hospitals in calm surroundings and lasted about 20 minutes. (Papers III, IV)

Four different instruments were used to evaluate respect and the associated fac–tors perceived by older patients: 1) the ReSpect Scale (designed for this study), 2) the CBI–Respectful Deference to Others (CBI–RDO, one subscale of the Caring Behaviours Inventory, CBI–24, Wolf et al. 2003, Wolf 2006) as a criterion instrument, 3) the Patient Satisfaction Scale (PSS, Kim 1999), and 4) the EuroQol 5D–5L (EQ–5D–5L, The EuroQol Group 1990, Herdman et al. 2011). The PSS as a measure of patient satisfaction and EuroQol 5D–5L were selected as a measure of health–related quality of life and to measure factors associated with perceived respect as identified in the literature review. The response options of the instruments were printed in a large font (Times New Roman 20) for older patients. The interviewers repeated the answers given by the respondents and documented their evaluations on the scales while the patient observed. (Peel & Wilson 2008) (Papers III, IV)

The ReSpect Scale

The ReSpect Scale (Copyright Jaana Koskenniemi © 2015, jakako@utu.fi, Turku University) was developed using inductive reasoning based on the interviews with older patients and their next of kin and by utilising respect literature. The instrument development proceeded as a process and included several partly overlapping steps (Waltz et al. 2005, Streiner & Nordman 2008, DeVellis 2003). In the first step, operational definitions of respect were created based on the analysis of Phase I, and a blueprint for the instrument was constructed. The item pool (48 items) was created in the second step. In the third step, the relevance and clarity of the items were assessed by the first expert panel (n=10) leading to the reduction of the items from 48 to 33. In the fourth step, the second expert panel (n=5) evaluated the items, and after critical discussions the number of items was further reduced to 23 items. In the fifth step, the instrument was pilot tested (n=30), and after minor revisions tested again among older hospital patients (n=200). (Paper III)

The ReSpect Scale has been developed in this study for the measurement of older patients' perceptions of respect in the care provided by nurses. The ReSpect Scale consists of two parts: part A, Nurses' Being with patients and part B, Nurses' Doing for patients. Nurses' Being with has two subscales, the first measuring respect as shown by nurses' essence (four items), and the second measuring respect in nurses'

commitment (three items). Nurses' Doing for has four subscales of four items each measuring respect in nurses' actions: accepting, listening, encouraging, and nurturing. The ReSpect Scale uses a Visual Analogue Scale (VAS) with a response range from 0 (never) to 100 (always). For this study, the VAS was illustrated with pictures and colours (Paper III, Figure 1.) making the scale suitable for any participants who had a reduced abstract ability or a cognitive disorder (Williamsson & Hoggart 2005). The higher the scores, the more respect is perceived. Patients were asked to consider a mean value that described their assessment of the respect they received from the nurses in each of the items of the ReSpect Scale. The ReSpect Scale takes approximately 10 to 15 minutes to complete and is easy to administer. In this study, the data were collected by individual interviews, but it is possible to also use it as a self–report measure. (Paper III) The ReSpect Scale, its parts, subscales, and content of items are presented in the Table 15, page 61.

Sociodemographic data were collected with structured questions on the patients' age, gender, marital status, basic and vocational education, occupation and living situation to describe what kind of older patients participated in this study. Environment–related data were collected on the reason for hospital stay assessed by the patient, chronic diseases assessed by the patient, the length of hospital stay, the number of beds in the patient's room, and the number of visits the patient's next of kin made per week. Additional items about the frequency of perceived respect in general, as well as good nursing care and genuine caring in general (on VAS scale 0–100) were also included. One open question was asked giving the patients the possibility to relate any other aspects concerning respect in the nursing care of older patients. (Papers III, IV)

CBI–Respectful Deference to Others (CBI–RDO)

The CBI–Respectful Deference to Others (CBI–RDO), one subscale of the Caring Behaviours Inventory (CBI–24, Wolf et al. 2003, Wolf 2006), was used as criterion instrument for the ReSpect Scale. CBI–24 is a short version of the CBI dveloped by Wolf et al. (2003) based on Jean Watson's Transpersonal Caring Theory (Watson 1985). The CBI–24 is used to measure the frequency of nurses' caring behaviours and can be administered to both patients and nurses. The CBI–RDO subscale has six items using a 6–point Likert–type scale with response options ranging from 1 (never) to 6 (always). Higher scores indicated more and lower scores less caring perceived. The CBI–24 has proved to be a valid and reliable tool for measuring caring behaviours practiced by nurses (Wu et al. 2006, Papastavrou et al. 2012). Cronbach's alpha coefficients for the CBI–24 total scale was 0.96 and for CBI–RDO 0.91 (Wu et al. 2006). The Finnish version of the CBI–RDO and permission for the use of the

CBI–RDO as a criterion instrument for the ReSpect Scale in this study was obtained on 14 Jan 2016 (Wolf, personal contact). (Papers III, IV)

EuroQol 5D–5L

The EuroQol 5D–5L (EQ–5D–5L, The EuroQol Group 1990, Herdman et al. 2011) instrument was selected to evaluate patients' perceived health as a factor associated with the respect they perceived. Some prior studies about respect suggest there may be connections between respect in nursing care and patients' perceived health status (DeHart et al. 2009, Oosterveld–Vlug et al. 2014).

The EQ–5D–5L is a generic preference–based instrument developed by the EuroQoL group and is extensively used for the self–assessment of health–related quality of life or perceived health status (The EuroQol Group, 1990; Herdman et al., 2011). The EQ–5D–5L consists of an illustrative system and a visual analogue scale (EQ–VAS). The illustrative system has five dimensions: mobility, self–care, usual activities, pain or discomfort, and anxiety or depression with five levels of severity in each: no; slight; moderate; severe; and extreme problems. The EQ–5D–5L generates a health profile that classifies the patient into one of 3125 possible theoretical health states. The result expresses the perceived health status as a single index value (the EuroQol index) calculated from the profile (EuroQoL Group 2015). The higher the index score, the higher the perceived health status. The validity and reliability of the descriptive system has been extensively tested (e.g. Herdman et al., 2011, van Hout et al., 2012). A Cronbach's alpha coefficients of 0.69 has been reported for the EQ–5D–5L (Hernandez et al. 2019). The Finnish version of the EQ–5D–5L was obtained from the EuroQol Group on Feb 2016 after registering the study on the organisation's request forms. In this study, the EQ–5D–5L was used for the self–assessment of perceived health status. The EQ–VAS was used to depict patients' perceptions of their current health status on a vertical visual analogue scale classified between "best imaginable health state" (100) and "worst imaginable health state" (0). The Finnish version of the EQ–5D–5L and permission for the use of it in this study was obtained on 30 Nov 2015 (e–mail from Mandy van Reenen, EuroQol Research Foundation). (Papers III, IV)

Patient Satisfaction Scale (PSS)

The Patient Satisfaction Scale (PSS, Kim 1999) was selected to evaluate older patients' satisfaction with nursing care as a factor associated with the respect they perceived. The earlier literature indicates there may be associations between respect conveyed by nurses and patients' assessments of their satisfaction with nursing care literature (Johansson et al. 2002, Berglund 2007, Suhonen et al. 2012).

The PSS was devised to investigate adult patients' satisfaction in relation to accessibility, ability and the conduciveness of care received by nurses to meet patients' technical/scientific care needs, information care needs, and interaction/support needs. The answer format is a four–point Likert–type scale (1=highly unsatisfied, 2=unsatisfied, 3=satisfied, and 4=highly satisfied) and produces one score for the scale (1–4). The higher the score the more satisfied the patient. The original nine–item PSS has been further developed into a 10–item (see Suhonen et al. 2007) and 11–item (see Suhonen et al. 2012) versions by separating the questions on the ways nurses prepared patients and relatives for the hospital stay and how they discharge them. The 11–item version was used in this study. The Cronbach's alpha coefficients for the 11–item PSS total scale was 0.91 and for the sub–scales was 0.84–0.91 Palese et al. (2011). Permission for the use of the PSS in this study was obtained on 15 Jan 2016 (personal contact, e–mail from the developer Hesook Suzie Kim) (Papers III, IV)

5.3 Data analysis

The data analysis in this study consisted of a qualitative data analysis and statistical analysis: content analysis and construction of a typology (Phase I), techniques for development of an instrument and descriptive statistics (Phase II) and statistical analysis (Phases II, III).

In Phase I, the data from the first interview study (data I) were analysed inductively using content analysis aiming to define and describe respect in nursing care from older patients' point of view. Progression of the analysis followed the instructions of Grandheim & Lundman (2004) and Patton (2002) and the applications are described in Table 13. The three researchers discussed and agreed upon the categories. (Paper I)

Table 13. Inductive content analysis used in Phase I (data I, II) (according to Grandheim & Lundman 2004 and Patton 2002).

STEP 1	Tape recorded interviews were transcribed verbatim.
STEP 2	Text was divided into meaning units based on the manifest content.
STEP 3	The meaning units condensed and coded.
STEP 4	The meaning units grouped together based on the same content area.
STEP 5	The content areas were sorted into subcategories.
STEP 6	The main categories were formed based on the similarity of the content.
IN EACH STEP	The categories were compared to the original data and synthesized based directly on the interviewees' conceptions and experiences.

The data from the second interview study (data II) were analysed in two periods. An initial inductive content analysis was followed by the construction of a typology describing the manifestation of respect in a patient–nurse relationship. In the first period, the analysis followed the steps described in Table 13. In the second period, the typology was formed focusing on the relationship between a patient and a nurse and the levels of respect manifested in the nurses' being and doing, also including patients' responses to the different levels of the manifested respect. (Paper II) (Macduff 2007).

In Phase II, two expert panels (n=10 and n=5, experts in nursing ethics) were conducted to assess content and face validities of the item pool of the instrument. The members of the first panel (n=10) evaluated and scored the relevance (1 = not relevant – 4 = very relevant) and clarity (1 = not clear – 4 = very clear) of each item in the item pool (48 items). By using 80 % agreement (agreement percentage over 78 %, Waltz et al. 2005) on relevance and clarity of the items (a score of 3 or 4) in the first expert panel (n=10), the number of the items were reduced from 48 to 33. Based on critical discussions in the second expert panel (n=5) and seminars, the items were further specified, and similar items were combined leading to a consensus on a 23–item ReSpect Scale. (Paper III)

The pilot test of the ReSpect Scale with older hospital patients (n=30) supported the clarity of the items and the instructions for the participants while also indicating that the use of the Visual Analogue Scale (VAS) with a response range from 0 (never) to 100 (always) worked better with the items than the use of a 5–point Likert–type response format going from strong disagreement to strong agreement with a neutral midpoint (Grove et al. 2013, Tavakol & Dennick 2011, Taber 2017). (Paper III)

In Phase III, the data (data V) were analysed using the statistical software package SAS 9.3 (SAS Inc., Cary, North Carolina, USA). Different statistical methods were used to analyse the main data (n=196) (Table 14.). Descriptive statistics were used to describe the study variables (frequencies, percentages, means, standard deviations, ranges, Shapiro–Wilk test, and 95 % Confidence Intervals). The total sum scores were calculated for all the instruments used in this study, i.e. The ReSpect Scale, CBI–RDO, PSS, EQ–5D–5L and EQ–VAS, by summing the item values and dividing the sum by the number of items (Grove et al.2013). In addition, eight sum scores were calculated for the ReSpect Scale: one for both parts, A (7 items) and B (16 items), and six for the subscales (two for part A and four for part B). The Shapiro–Wilk test was used to check whether the variable was normally distributed in the data, and a 95 % Confidence Intervals was used to revise the distribution (DeVellis 2003, Grove et al. 2013). (Papers III, IV).

Different psychometrics were used to analyse the study variables. Cronbach's alpha coefficients were calculated for the total of the ReSpect Scale, for its parts, and

for the subscales as a measure of internal consistency (Rattaray & Jones 2007), as well as to the other scales used in this study (PSS, EQ–5D index score, and EQ–5D–VAS) to assess the psychometric properties (DeVellis 2003, DeVon 2007). Item analysis was used to analyse how each item in the ReSpect Scale fitted the subscale (item to total > 0.30, range: 0.78–0.91) and how the items fitted with others within the subscale ($0.3 < r < 0.7$, range: 0.68–0.86), as regards supporting the theoretical basis of the phenomenon (DeVellis 2003, DeVon et al. 2007, Rattray & Jones 2007). A Principal Component Analysis (PCA) with Promax rotation was used to support the construct validity of the ReSpect Scale by estimating the theoretical construction of the scale (explaining 84.5% of the variance of the Part A and 84.8% of the Part B). (Papers III, IV)

Inferential statistics were used to make inferences and predictions concerning the data (Grove et al. 2013). Pearson's correlation coefficient was calculated between the ReSpect Scale and the CBI–RDO ($r = 0.83$, $p < 0.001$) as regards supporting the criterion validity and considering the value of ≥ 0.45 as being acceptable (DeVon et al. 2007). (Paper III) Further, Pearson's correlation coefficients were used to test the associations between the study variables (perceived respect, health status and patient satisfaction). Moreover, nonlinear associations were tested by re–categorising the perceived health and patient satisfaction data into four equal groups, using quartiles (Q1–Q4) and naming them poor (Q1), moderate (Q2), good (Q3), and excellent (Q4) perceived health and satisfaction with nursing care. With a T–test and an analysis of variance (ANOVA) the associations between background variables and the ReSpect Scale total were examined. ANOVA was also used to compare the quartiles of the EQ–D index and PSS. Tukey–Kramer was used to find out differences between the quartiles. (Paper IV).

Table 14. Statistical methods used in main data (n=196) in Phase III.

Target for analysis	Method
Characterization of the variables	**Descriptive statistics**
Description of the sample and study variables	Frequency, percentage
Description of the sample and study variables	Mean, standard deviation, range
Distribution normality of the variable	Shapiro–Wilk test
The % of the confidence interval that will contain the true population mean	95 % Confidence Intervals
Construction and validation of the instrument	**Psychometrics**
Internal consistency of the instrument	Cronbach's alpha
Correlation of an item to its upper construct, item analysis	Item–to–total correlations
Intercorrelations of the items within a scale, item analysis	Item–to–item correlations
Construct validity of the instrument	Principal component analysis
Adequacy of the sample size for PCA	Kaiser–Meyer–Olkin test
Suitability of data for factoring	Barlett's test of sphericity
Associations between numerical variables	**Inferential statistics**
To find associations between the main study variables	Pearson's correlation
To determine a significant difference between two groups	T–test
Associations, three or more groups	Analysis of variance (ANOVA)
Post hoc comparisons	Tukey–Kramer

5.4 Ethical considerations

This is a study of nursing ethics in the context of older peoples' nursing care. The research topic of this study concerned older peoples' experiences and perceptions of respect in nursing care and the questions assessed have ethical value and importance in the development of health care organisation and nursing care. The research approach and study questions were justified because of limited empirical evidence about this topic (Gallagher 2004, Gallagher et al. 2008) and the obstacles identified in earlier studies (DeHart et al. 2009, Buzgova & Ivanova 2011, Moe et al. 2013).

The basic principles of research ethics were adhered to in every phase of this study: Tutkimuksen eettinen arviointi Suomessa (ETENE 2019), Ethics for re–searchers (European Commission 2013), Operating procedures of the national committee on medical research ethics (TUKIJA 2011), Responsible conduct of research and procedures for handling allegations of misconduct in Finland (TENK 2012), Declaration of Helsinki (WMA 2013), and The European code of Conduct for Research Integrity (ALLEA 2017), all highlight the researcher's obligation to

protect human rights and human dignity, and to secure the interests and wellbeing of research subjects. When investigating sensitive issues involving vulnerable patients specific ethical questions are emphasised throughout the research process (Hubbard et al. 2003, Pesonen et al. 2011). The older patients in this study were in a vulnerable situation. They were recovering from major operations or acute illnesses or they had memory disorders all of which could threaten their identity, self–determination, and independence. The key ethical principles guiding this study were beneficence and respect for the autonomy of the participants (Pesonen et al. 2011, ANA 2016). Older patients were chosen as the participants in this study as they are the largest group of patients in the healthcare system and have the right to have their voices heard.

Ethical approvals for both studies in the first phase were obtained from the ethical committee of the hospital district (26/180/2009 and 71/180/2010), and in Phase III from the ethical committee of the university (44/2015). Permissions for the study and data collection in all the phases were obtained according to each organisation's practices before data collection. Furthermore, approvals for the use of the instruments used in this study were obtained from the copyright holders (CBI–RDO, 14 Jan 2016; PSS, 15 Jan 2016; and EuroQoL 5D, 30 November 2015).

The organisations that participated in this study were informed by the research–er and all the data were collected by face–to–face. The head ward nurses of the departments (Phases I and III) were informed about the aims and practical implementations of the studies (One example on Appendix 3.). The participants (Phases I and III) were recruited with the help of the contact nurses on each ward using the inclusion criteria. After an initial oral consent for the participation, the researcher met the participants and provided them with more substantial information (Appendix 4 and 6.) about the purpose of the study, and that the principles of voluntariness, anonymity, and confidentiality would be followed at every stage of the data handling process (ALLEA 2017). Participants were aware that participation or refusal did not have an impact on their care provision. Signed informed consent statements (Appendix 5) were obtained from all participants before data collections.

Trust is vital when interviewing any patients (Peel & Wilson 2008, Watson et al. 2008). In both empirical Phases (I and III), the participants had time to consider their participation and prepare further questions about the study. Some participants were willing to participate immediately, while others needed more time to think about it. Studying older people might evoke strong feelings among some of the patients or their next of kin (Peel & Wilson 2008). The participants received an option to contact the researcher, if they were at all bothered by the study. No–one made use of this option. However, the interviews were often followed by informal discussions about the research topic, which the participants felt to be important. (Koskenniemi et al. 2014)

All the data from patients and their next of kin were collected by face–to–face interviews: individual open interviews in Phase I and face–to–face interviews with structured questions in Phase III. Separate individual interviews were selected in Phase I to avoid any influence by their next of kin on the patients' perceptions (Moore & Hollet 2003, Sugarman et al. 2007). The interviews took place in a familiar and calm environment chosen by the participants, typically in the hospital or at home. All participants were carefully observed for any signs of distress, tiredness, or the need to interrupt the interview. The interviews resembled a conversation where the older patients and their next of kin felt free to share their personal experiences with the researcher (Sugarman et al. 2007, Peel & Wilson 2008).

Each member of the expert panels (Phase II) received orally and written information about the study and the aims of the expert panel (Appendix 6.). Their expertise on the topic was highly appreciated in the discussions. All the panellists returned the evaluation form which indicated their informed consent.

In reporting the results of the study, a special focus was placed on anonymity when making minor revisions to the authentic quotations in both the interview data sets in Phase I. In addition, by processing each empirical data as a whole (Phase I and III) made it impossible to compare care settings, hospitals or wards in the study report. All data were saved according to Turku University guidelines in university networks where the access was only allowed for the researcher (JK).

An important ethical requirement is that the researcher is responsible for evaluating the significance and utilitarian value of the study for the society (ALLEA 2017). Stakeholders and leaders of health care organisations will be informed about the results of this study in order to make the voice of older patients stronger in health care and nursing practice.

6 Results

The results will be present according to the phases, aims and research questions of the study. First, the definition and manifestation of respect from older patients' point of view are described (6.1) followed by a description of the ReSpect scale for the measurement of respect perceived by older patients (6.2). Subsequently, the respect perceived by older patients (6.3) and factors associated with respect perceived by older patients are then reported (6.4). Lastly, a summary of the main results are presented (6.5).

6.1 Definition and manifestation of respect from the perspective of older patients

Definition of respect in nursing care from older patients' point of view

In the Phase I, two interview studies were conducted to develop the theoretical basis for the measurement of respect perceived by older patients. The theoretical basis of respect perceived by older patients is described in the Figure 3.

The first interview study was conducted to discover what is considered respect for older patients in nursing care. Based on the analysis of older patients' experiences, and confirmed by their next of kin, the concept of respect in nursing care from older patients' point of view can be defined in terms of actions taken by the nurse and the next of kin, and factors related to the environment. Altogether eight nurse–related actions, three next of kin–related actions and five environment–related factors were identified. (Paper I).

Nurse–related actions, such as polite behaviour, the patience to listen, reassurance, and responses to patients' needs and wishes, played a central role in older patients' experiences of being respected by nurses. Respect demonstrated in nurse–related actions were felt to make a safe and caring environment where older patients felt free to ask questions, get help and express their personal wishes. Next of kin–related actions also played a crucial role in older patients' experiences of being respected in nursing care. The next of kin were felt to be supporters, assistants and advocators who actively defend older patients' rights and take part in decision

making. To be respected in connection to environment–related factors was experienced by patients as a reflection of the general appreciation of older people in society (e.g. alignments of care performed), the management of health care organisations (e.g. adequacy of the staff, amount of work performed by the nurses), the nursing culture (e.g. nurses' motivation and willingness to help patients), the flow of information (e.g. relevant and up–to–date information), and patient placement (e.g. thoughtfulness concerning roommates). The results expressing the need to both notice and respond to older patients with kindness, patience, and expertise, lead to the conclusion that there needs to be a closer analysis of respect in a patient–nurse relationship. (Paper I)

Manifestation of respect in a patient–nurse relationship

Nurse–related actions are central to the older patients' experiences of respect in nursing care. This was the reason why respect was further examined and analysed in the patient–nurse relationship. The results revealed that respect manifests itself in nurses' being and doing (Paper II), (Figure 3.).

Respect as shown by nurses' being were concerned with being humane (e.g. being patient, friendly, easy to approach and sympathetic), being discreet (e.g. being considerate and sensitive), being skilled (e.g. being educated and experienced), and being motivated (e.g. being positive and helpful). Respect as shown by nurses' doing were concerned with valuing (e.g. behaving politely and kindly, and taking into consideration patients' perspectives), interacting (e.g. conversing and leaning to know the patient), supporting (e.g. assisting patients' remaining abilities and encouraging participation), and nurturing (e.g. taking care of basic care needs, being flexible in routines). (Paper II)

The further analysis of older patients' experiences provided a three level typology of nurses' being and doing regarding the manifestation of respect and the subsequent patient responses. Older patients felt they were respected by nurses who conveyed to feeling: "I'm here for you". These nurses were felt to concentrate fully on their patients and achieve mutual understanding by being caring, considerate, friendly, and helpful. With these nurses, older patients felt they had possibilities to be active in their own care, to share their thoughts and experiences, and to express questions, wishes and needs. Nurses who were felt to convey: 'I'm here for work', were considered to just concentrate on their duties rather than on their patient, and were felt to be absent, distant, and routine. With these nurses, patients felt they were forced to explore and seek for suitable moments to express e.g. their needs. Older patients did not experience they were respected by nurses who conveyed an attitude: "I'm not here for you". These nurses were felt to disregard their patients by being careless, unfriendly, and unhelpful. With these nurses, older patients withdrew,

became silent and felt they had no possibility to take part in their own care. (Paper II)

Respect expressed in nurses' being and doing allows for the development of a mutual understanding between the patient and nurse and facilitates patient independence. As the nurses' manifestation of respect decreased, also the understanding between the patient and the nurse decreased and opportunities for the patient to actively participate in their own care were reduced. Where the manifestation of respect in nurses' being and doing was not shown, there was no understanding between patients and nurses, and patients were not active in their care. Manifestation of respect in nurses' being and doing provides a theoretical basis for the meaning of respect perceived by older patients. (Paper II)

Descriptions of definition and manifestation of respect formed together the theoretical basis of respect perceived by older patients. On the basis of this, respect in nursing care as perceived by older patients is defined in this study in terms of the extent to which older patients perceive respect in nurses' ways of interaction with them, that is, nurses' manner of being and doing. Respect in nurses' being with patients is related to nurses' essence and the way they commit to caring for older patients; and respect in nurses' doing for patients is related to nurses' actions expressing acceptance, listening, encouraging, and nurturing. Respect in nurses' being with and doing for is revealed by their caring attitudes and behaviours and reflected in their ethical knowledge and professional values. (Papers I–IV)

6.2 The ReSpect Scale, an instrument to measure the respect perceived by older patients in the care provided by nurses

Operational definitions provide means to illustrate theoretical concepts in concrete situations and thereby to contribute to the empirical relevance of the concepts (Rattray & Jones 2007). The theoretical basis of respect perceived by older patients (Figure 3.) guided the development process of the items in the ReSpect Scale. Patients' perceptions of respect in nurses' being and doing were defined in the ReSpect Scale in a structured way using the older patients' own words. Two expert panels (experts in nursing ethics, n = 10, n = 5) analysed the relevance and clarity of the items (n = 48), leading to combinations and specifications of the items, and after discussions the number was reduced to 23 items. The pilot test with older hospital patients (n = 30) supported the clarity of the items and the instructions to participants and standardised the measurement technique. (Paper III, Table 1.)

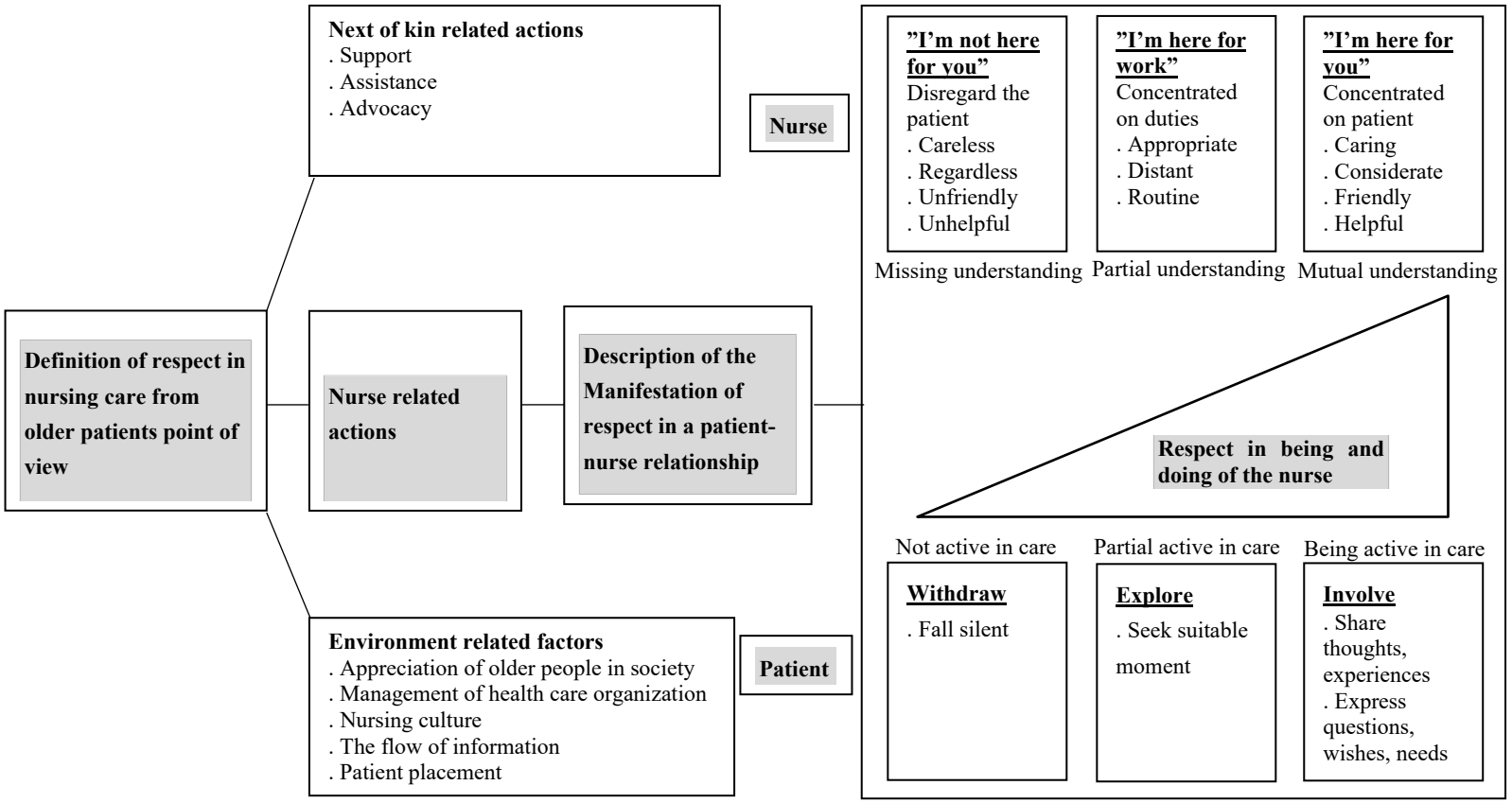

Figure 3. The theoretical basis of respect perceived by older patients in the study. (Modified from the Figure 1, Paper I and from the Figure 1, Paper II, with the permissions of the copyright holders of Nursing Ethics and Scandinavian Journal of Caring Sciences)

The ReSpect Scale consists of two parts (part A, Nurses' Being with patients and part B, Nurses' Doing for patients) and six subscales. Nurses' Being with has two subscales (Essence, four items; Commitment, three items), and Nurses' Doing for has four subscales of four items each (Accepting, Listening, Encouraging, and Nurturing). The ReSpect Scale measures the frequency of respect older patients perceive in the care provided by nurses. (Paper III)

The ReSpect Scale uses a modified Visual Analogue Scale (VAS) with a response range from 0 (never) to 100 (always) (Figure 4). The higher the scores, the more frequent the perceived respect. Patients were asked to think of an average value that described their evaluation of the respect they received from the nurses in each of the items of the ReSpect Scale. The ReSpect Scale takes about 10 minutes to complete and is easy to administer. The data could be collected by individual interviews as well as self–reported measures. The ReSpect Scale, its parts, subscales, and content of items are presented in the Table 15. (Paper III)

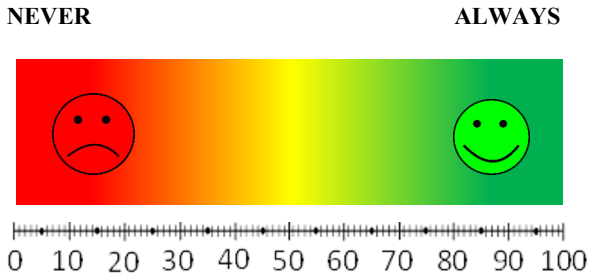

Figure 4. The visual modification of the VAS used in this study. (From original publication, Figure 1, Paper III, with permission of the copyright holders of International Journal of Older People Nursing).

The psychometric properties tested by hospital patients (n = 196) demonstrated the potential of the ReSpect Scale to effectively measure the respect perceived by older patients in the care provided by nurses (Table 15.). Cronbach's α value for the total ReSpect Scale was 0.98 and for its parts 0.93 (A) and 0.97 (B). For the subscales, the values ranged from 0.91 to 0.93. Item–total correlations were between 0.78–0.91 while interitem correlations ranged from 0.68 to 0.86. The Barlett's test (< 0.0001) suggested the data allowed for the factor construction (criteria $p < 0.05$) and the Kaiser–Meyer–Olkin test (0.956) indicated that the sample size was suitable for factor analysis. (Paper III)

Principal Component Analysis (PCA) with Promax rotation supported the theoretically constructed two factors of part A, Being with, and four factors of part B, Doing for, explaining 84.5 %– 84.8 % of the variance, respectively. However,

some overlapping concerning items 8, 12 and 22 were found indicating the similarity of the subscales. (Table 16.) (Paper III)

Table 15. Psychometric properties of the ReSpect Scale (n=196). (Modified from Table 2, Paper III).

Scales and abbreviated items	Cronbach α	Item–total correlation	Interitem correlation
ReSpect Scale total	0.98		
(A) Nurses' *Being with*	0.95		
The essence of the nurse	0.92		
being approving		0.78	0.69–0.74
being an active listener		0.84	0.72–0.81
being supportive		0.81	0.69–0.77
being attentive		0.86	0.74–0.81
The commitment of the nurse	0.92		
being motivated to care		0.82	0.75–0.82
being proficient to care		0.88	0.82–0.84
being suited for caring for		0.83	0.75–0.84
(B) Nurses' *Doing for*	0.97		
Accepting	0.91		
accepted me as I am		0.80	0.64–0.75
had appreciated discussions with me		0.82	0.72–0.75
empowered me in my own habits		0.78	0.68–0.74
treated me equally as others		0.81	0.72–0.75
Listening	0.93		
showed interest in my perspectives		0.81	0.71–0.78
allowed me time to express myself		0.86	0.78–0.82
took my views seriously		0.87	0.77–0.83
understood me		0.85	0.71–0.83
Encouraging	0.93		
acknowledged me positively		0.80	0.68–0.80
supported my individual capacities		0.89	0.79–0.86
encouraged me to take part in care		0.80	0.68–0.79
worked to maintain my hope		0.87	0.77–0.86
Nurturing	0.95		
were available when I needed		0.89	0.81–0.86
helped me in many, indefinable ways		0.91	0.84–0.86
worked to improve my wellbeing		0.87	0.81–0.86
created a safe caring atmosphere		0.88	0.81–0.84

Table 16. Construct validity of the ReSpect scale based on a Principal Components Analysis (PCA) with Promax rotation (n=196). (Modified from Table 3, Paper III).

Sub–scale	Item no	Abbreviated items of (A) Nurses' *Being with* sub–scales	Factor1	Factor2		
Essence	1	being approving	0.65	0.27		
	6	being an active listener	0.71	0.26		
	11	being supportive	0.97	–0.07		
	16	being attentive	0.75	0.22		
Commitment	22	being motivated to care	**0.53**	0.47		
	23	being proficient to care	0.00	0.95		
	24	being suited for caring for	0.16	0.83		
Variance explained by each factor ignoring other factors, %			69.5	64.0		
Kaiser–Meyer–Olkin Measure			0.930			
Barlett's test based on n=196			p < 0001			
Sub–scale	**Item no**	**Abbreviated items of (B) Nurses' *Doing for* sub–scales**	**Factor1**	**Factor2**	**Factor3**	**Factor4**
Accepting	2	accepted me as I am	0.94	–0.07	–0.07	0.12
	3	had appreciated discussions with me	0.69	0.32	0.08	–0.10
	4	empowered me in my own habits	0.64	0.08	0.20	0.03
	5	treated me equally as others	0.71	0.01	0.23	0.01
Listening	7	showed interest in my perspectives	0.04	0.36	0.03	0.60
	8	allowed me time to express myself	**0.39**	0.12	0.31	0.25
	9	took my views seriously	0.07	0.00	0.26	0.72
	10	understood me	0.32	0.03	0.25	0.45
Encouraging	12	acknowledged me positively	–0.01	0.54	–0.12	**0.58**
	13	supported my individual capacities	–0.03	0.80	0.15	0.09
	14	encouraged me to take part in care	0.12	0.71	0.18	–0.02
	15	worked to maintain my hope	0.06	0.84	0.02	0.07
Nurturing	17	were available when I needed	0.13	0.03	0.76	0.07
	18	helped me in many, indefinable ways	0.14	0.05	0.80	0.03
	19	worked to improve my wellbeing	–0.01	0.13	0.80	0.07
	20	created a safe caring atmosphere	0.26	0.15	0.56	0.05
Variance explained by each factor ignoring other factors, %			55.6	51.9	58.3	47.5
Kaiser–Meyer–Olkin Measure			0.956			
Barlett's test based on n=196			p < .0001			

6.3 Respect perceived by older patients

Even though older patients quite frequently perceived respect in nurses' care (ReSpect Scale total M = 76.4, SD = 17.8, max = 100), the results specified the areas where respect for older patients could be improved (Table 17.) (Paper III).

The results indicated that around 25 % of patients felt they were less frequently being respected. Patients perceived respect in nurses' ways of Doing for them (M = 75.9, SD = 18.0) a little bit less frequently than in nurses' ways of Being with them (M = 77.5, SD = 17.7), indicating that nurses may convey respect to their patients more in thought (the essence) than in deeds (actions). The area where there was the most room for improvement was the frequency of listening (Showed interest in their patients' views, M=68.4, SD=22.7) and encouraging (Acknowledged patients positively, M=71.4, SD=23.1). (Paper III)

The first subscale in Part A Being with, represents the essence of the nurse, and the participants perceived nurses to be the least supportive in this regard (M = 74.1, SD = 22.1). Moreover, the range of answers varied from never (0) to always (100) for this item, indicating that there was considerable variation in patients' perceptions. With reference to the second subscale in Part A, portraying the commitment of the nurse, participants perceived nurses to be least frequently motivated to care (M = 77.1, SD = 21.2). (Paper III)

In Part B Doing for, participants felt listened to (M = 74.4, SD = 19.4) and encouraged (M = 73.3, SD = 20.8) less frequently than accepted (M = 78.4, SD = 17.3) and nurtured (M = 77.6, SD = 19.6). Within the encouraging subscale, three items varied from never (0) to always (100), suggesting remarkable variation in patients' perceptions of nurses' ways of supporting patients' individual capacities, encouraging patients to take part in their own care and working to maintain patients' hope. Within the accepting subscale, the area with the most room for improvement was the frequency of empowering patients in their own habits (M = 75.2, SD = 20.4), and within the nurturing subscale, the frequency of being available when patients needed them (M = 76.7, SD = 22.0). (Paper III)

In summary, older patients' perceptions varied and not all patients perceived respect. The areas needing improvement were acknowledging older patients positively whilst taking an interest in and supporting their individual capacities. These results provide support for the different levels of typology of respect perceived by older patients described in the theoretical basis (Figure 3.) (Paper III)

Table 17. Frequency of respect perceived by older patients (n=196) in the care provided by nurses. (Modified from Table 2, Paper III).

Scales and abbreviated items	Mean	SD	Range
ReSpect Scale	76.4	17.8	11.2–100
(A) Nurses' *Being with*	77.5	17.7	10.0–100
The essence of the nurse	76.5	18.0	11.2–100
Being approving	77.1	18.0	25.0–100
Being an active lister	77.2	19.5	5.0–100
Being supportive	74.1	22.1	0–100
Being attentive	77.6	20.5	5.0–100
The commitment of the nurse	77.8	18.6	8.3–100
Being motivated to care	77.1	21.2	10.0–100
Being proficient to care	80.8	19.2	5.0–100
Being suited for caring for	78.6	19.5	10.0–100
(B) Nurses' *Doing for*	75.9	18.0	11.8–100
Accepting	78.4	17.3	21.3–100
Accepted me as I am	79.4	18.1	25.0–100
Had appreciated discussions with me	76.4	21.1	10.0–100
Empowered me in my own habits	75.2	20.4	10.0–100
Treated me equally as others	82.8	17.7	10.0–100
Listening	74.4	19.4	7.0–100
Showed interest in my perspectives	68.4	22.7	6.0–100
Allowed time to express myself	76.1	20.8	10.0–100
Took my views seriously	75.2	21.4	6.0–100
Understood me	77.7	19.9	6.0–100
Encouraging	73.3	20.8	2.5–100
Acknowledged me positively	71.4	23.1	10.0–100
Supported my individual capacities	72.9	22.7	0–100
Encouraged me to take part in care	74.2	22.7	0–100
Worked to maintain my hope	74.5	22.7	0–100
Nurturing	77.6	19.6	10.0–100
Were available when I needed	76.7	22.0	0–100
Helped me in many, indefinable ways	78.3	20.7	3.0–100
Worked to improve my well–being	76.9	20.5	10.0–100
Created a safe, caring atmosphere	78.6	20.7	5.0–100

6.4 Factors associated with respect perceived by older patients

To obtain a deeper understanding of older patients' perceptions of respect and to facilitate its identification and measurement, perceived respect (ReSpect Scale) was analysed in relation to patients' sociodemographic characteristics, perceived health status (EuroQol 5D–5L and EQ–VAS) and satisfaction with nursing care (Patient Satisfaction Scale, PSS) (Paper IV).

Overall, older patients (aged M = 82.1, SD = 8.13) perceived respect in their care quite frequently (ReSpect Scale, M = 76.4, SD = 17.8), were quite satisfied with their nursing care (PSS, M = 3.03, SD = 0.46), and perceived their health as average (EuroQol 5D index, 0.60, SD = 0.26 and EQ VAS score 56.4, SD = 18.2) (Table 18). (Paper IV)

Table 18. Measurements and intercorrelations between respect and its associated factors. (Modified from Tables 2–3, Paper IV).

Variable	Instrument	Number of items	Mean	SD	95% CI for the mean	Correlation to ReSpect total
Perceived respect	ReSpect Scale	23	76.4	17.8	73.89–78.89	1.00
Satisfaction with nursing care	PSS	11	3.03	0.46	2.97–3.10	0.75***
Perceived health status	EuroQol 5D index	5	0.60	0.26	0.56–0.64	0.30***
	EQ–VAS	1	56.4	18.2	53.81–58.95	0.15*

Significance of the correlation *P<0.05; **P<0.01; ***P<0.001.

Statistically significant intercorrelations between the PSS, EQ–5D index score and EQ–5D–VAS were also found (Table 3. in Paper IV). A statistically significant strong positive correlation was found between patients' satisfaction with nursing care (PSS, r= 0.75, $p < 0.001$) and their perceptions of respect provided by nurses, this indicated that respect for patients in nurses' 'being with' and 'doing for' played a crucial role in patients' assessments of their care satisfaction. A moderately significant positive correlation was found between perceived health (EQ–5D–5L, r = 0.30, $p < 0.001$) and perceived respect, and a small but statistically significant positive correlation between health status (EQ VAS, r = 0.15, $p < 0.05$) and perceptions of being respected by nurses. (Paper IV)

Older patients' perceptions of respect shown by nurses' being with and doing for them varied and deficiencies were also perceived (Table 17.) which led to a more

detailed examination of the associations between perceived health status, perceived care satisfaction, and perceived respect (Table 19.). Examination of the associations in quartiles indicated a statistically significant difference between poor health status and all other health quartiles (moderate, good, or excellent) indicating that older patients with poor health status perceived respect less frequently in the care provided by nurses. This was an important finding, and it offers support for the different levels of typology of respect perceived by older patients described in the theoretical basis (Figure 3.) Another interesting finding was that where a better health status was perceived, there were no significant differences in perceived respect indicating that older patients with a moderate, good, or excellent health status perceived respect with the same frequency. (Paper IV)

Table 19. Associations between EQ–5D index, PSS and ReSpect total scores examined in Quartiles. (Modified from Table 4, Paper IV).

Quartiles	n	ReSpect total Mean (SD)	Pairwise differences between the quartiles
EQ–5D index			
Q1 Poor	49	66.7 (18.5)	Q1–Q2, p=0.0237 Q1–Q3, p<.0001 Q1–Q4, p=0.0012
Q2 Moderate	50	76.4 (18.4)	
Q3 Good	48	82.4 (14.4)	Q2, Q3, Q4, no significant differences
Q4 Excellent	48	79.7 (15.6)	
PSS			
Q1 Poor	44	56.0 (17.2)	
Q2 Moderate	64	74.6 (13.0)	all differences significant, p = 0.0001 – 0.0101
Q3 Good	40	83.2 (10.5)	
Q4 Excellent	47	91.6 (6.7)	

No statistically significant associations between patients' perceptions of respect and any of their sociodemographic variables were found. However, some trends could be observed. Patients who were not able to give the reason for their hospitalisation (6%, n=11) gave the highest scores (M=80.5, SD=12.5) for perceived respect while patients who went through surgery (18.4%, n=36) gave the lowest (M=70.4, SD=24). Further, higher scores were given (from 77.2, SD=16.5 to 79.8, SD=15.4) by the oldest old, male, and married patients, patients living with a next of kin, and patients having a secondary education in contrast to the lower scores given by the youngest old, female, and unmarried patients, patients living in sheltered housing, and patients having an academic education. (See paper IV, Table 1.)

6.5 Summary of the main results

This study produced the theoretical basis of respect perceived by older patients by defining respect in the nursing care of older patients (RQ1, Paper I) and by describing the manifestation of respect in a patient–nurse relationship (RQ2, Paper II). Further, this study created the ReSpect Scale for the measurement of older patients' perceptions of respect in the care provided by nurses (RQ3, Paper III), and the analysis of respect and its associated factors as perceived by older patients (RQ4, RQ5, Papers III, IV). The phases, research questions, main results and outcomes are presented in Table 20. (Papers I–IV, Summary)

Table 20. Phases, research questions, main results, and outcomes of the study.

PHASES/ PAPERS	RESEARCH QUESTIONS	MAIN RESULTS	OUTCOMES
Phase I Conceptual phase	RQ1: What is respect for older patients in nursing care experienced by older patients and their next of kin?	Respect for older patients in nursing care is defined by the actions taken by the nurse and the next of kin and by factors related to the environment.	**THE THEORETICAL BASIS OF RESPECT** PERCEIVED BY OLDER PATIENTS
Paper I Paper II	RQ2: How is respect manifested in a patient–nurse relationship?	Respect manifested itself in a patient–nurse relationship as nurses' ways of being with and doing for patients by conveying "I'm here for you", "I'm here for work", and "I'm not here for you", and patients' responses for these ways: "Share", "Explore" and "Withdraw".	
Phase II Instrumentation phase	RQ3: What are the elements of respect perceived by older patients in the care provided by nurses?	Respect in nurses' being with patients is related to two elements: the essence and the commitment of the nurse, and four elements related to nurses' doing for their patients: accepting, listening, encouraging, and nurturing.	**THE RESPECT SCALE** FOR THE MEASUREMENT OF RESPECT PERCEIVED BY OLDER PATIENTS IN THE CARE PROVIDED BY NURSES
Paper III			
Phase III Evaluation phase	RQ4: To what extent do older patients perceive respect in their care provided by nurses?	Older patients' perceptions on respect varied and not all patients felt respected. The room for improvements were on acknowledging older patients positively whilst taking an interest in and supporting their individual capacities.	RESPECT PERCEIVED BY THE OLDER PATIENTS AND FACTORS ASSOCIATED
Paper III			
Paper IV	RQ5: What are the associations between respect perceived by older patients and their sociodemographic characteristics, perceived health status and satisfaction with nursing care	Increased respect perceived by older patients may improve patients' perceived health status and increase their satisfaction with nursing care. No statistically significant associations between patients' perceptions of respect and any of their sociodemographic variables were found in this study.	

7 Discussion

In this chapter, the results are first discussed by considering the previous research results (7.1). Secondly, the validity and reliability of the study (7.2) is discussed, followed by the suggestions for the future research (7.3) and the practical implications of the study (7.4).

7.1 Discussion of the results

To be cared for with respect is considered a primary right of patients, and showing respect is a professional requirement in the delivery of ethical high–quality care. Respect has rarely been a topic of nursing research and no existing single instrument for the measurement of respect perceived by older patients could be found in the literature reviewed. However, this study provided a view on respect and initiated the possibilities for its measurement. In the following, the main results are discussed in three parts: firstly, a definition and description of respect perceived by older patients; secondly, a discussion about measuring respect perceived by older patients, and finally, a discourse on evaluating respect perceived by older patients and its associated factors.

7.1.1 Defining and describing respect perceived by older patients

This study fulfilled the knowledge gap in research by defining and describing respect in nursing care from older patients' point of view. Respect in nursing care from the perspective of older patients' point of view proved to be a broad and multidimensional concept including several nurse- and next of kin–related actions and environment–related factors (Paper I). Respect manifests itself in a patient–nurse relationship as nurses' being and doing and the patients' responses. Respect as shown by nurses' being and doing allows the development of a mutual understanding between a patient and a nurse, thus making it possible for older patients to be more involved in their care. (Paper II). The aim of empirically measuring respect forced restrictions on the definition of respect as perceived by older patients. Respect in nurses' care is defined in this study in terms of the extent to which older patients perceive respect in nurses'

being with and doing for them. Respect in nurses' being with patients is related to a nurse's essence and the way they the nurse committed to caring for older patients; and respect in nurses' doing for patients is related to a nurse's actions that express acceptance, listening, encouraging, and nurturing. (Papers III, IV.) Respect as shown by nurses' being with and doing for patients reveals caring attitudes and behaviours and is reflected in nurses' ethical knowledge and professional values (Papers, I–IV).

The uses of the concept of respect (Table 2, page 20), employed in this study, highlight patients' right to be respected and the professionals' obligation to show respect for their patients. The older patients, participating in this study, did not especially advocate their rights, or demand that nurses fulfill their obligations. Respect for these older patients was not a matter of the fulfillment of obligatory clauses. More exactly, it was a matter of the older patients' descriptions of the respect provided by nurses that mirrored the dictionary definitions used in this study; these definitions focused on respect as a pleasant and unforced responsibility expressing conformity, harmony, and flexibility (Table 1, page 18).

The dimensions (Dillon 1992) and orientations (Browne 1993, Gallagher 2004) of respect formed the framework of the respect perceived by older patients by describing the attributes and requirements needed for the manifestation of respect (Chapter 2.2). Elements of respect defined in this study give support for respect as providing observant attention (e.g. being attentive), active engagement (e.g. being motivated to care), and thoughtful responses (e.g. acknowledging positively). Further, the results of this study confirm that perceived respect requires nurses' to demonstrate caring attitudes and behaviours that are reflections of their ethical knowledge and professional skills.

The definitions and descriptions of respect in earlier literature were found to be widely dispersed and presented a general view that was fragmented (see 3.5). This study responded to the need to define and describe respect in nursing care and provided a novel description of respect in nursing care as perceived by older patients (see 6.1). Some elements of respect, defined in this study, could also exist in studies analyzing person–centredness (Dewin 2004) and patient–centredness (Abley 2012) in nursing care. For example, listening carefully to patients (Dewin 2004) and noticing patients' preferences (Abley 2012) are central to the patient–centred approach. Further, the results of this study emphasizing older patients' wish to be acknowledged positively, to be carefully listened to and encouraged to participate in decision–making processes, also receive theoretical support from conceptual frameworks defining patients as active participants concerning their care (Leino–Kilpi 1990, Suhonen 2002, D'Antonio et al. 2014). Moreover, respect in nurses' being with and doing for patients defined in this study, offers support for nursing theories concerning patients' requirements to have their needs fulfilled (Henderson 1966) and their person to be valued, recognised, and considered (Swanson 1991).

However, not all older patients felt they were respected by their nurses (Papers I–IV), as has also been identified in earlier studies (Williams 2006, Buzgova & Ivanova 2011, Emsfors et al. 2017). The earlier literature argued that it is not possible for caregivers to provide dignified care without, at the same time, developing their own character, integrity, and personal dignity including responsibility, accountability, and obligations to others (Coventry 2006). Working with this theoretical basis of respect (Figure 3) may help nurses to acquire a deeper understanding of respect from older patients' point of view and to develop the attitudes, skills and behaviours required to respect older patients in nursing care.

In this study, respect has been analysed in patient–nurse relationships. However, respect can also consider to be a broader phenomenon including environment–related factors, such as the management of health care organisations and the flow of information (Paper I). The results of this study could be used as a basis for future studies to analyse other manifestations of respect in the relationships of patients and professionals.

7.1.2 Measuring respect perceived by older patients

This study presented the possibility to measure respect in nursing care by developing the ReSpect Scale; a scale that evaluates patients' perspectives on the respect provided by nurses in care (6.2). The items of the ReSpect Scale were made by defining respect in a structured way using older patients' own words. The elements of respect presented reflect the most concrete aspects of respect perceived by older patients.

Comparing the elements of respect within the supplementary literature reviewed in this study, it may be important to add one other element concerned with information sharing (Thompson et al. 2011). Respect concerning information sharing may include items aiming to describe nurses' ways to inform patient of the task and its purpose (Percival & Johnson 2013), to explain care activities before delivering them (Hansebo & Kihlgren 2002, Chung 2012), and to explain things in an understandable manner (Bowersox et al. 2013). In the current scale, for example in the subscale of encouraging, it is not possible to encourage patients to become involved in their care without sharing information. Future studies are needed to confirm the theoretical basis of respect developed in this study, and to test the instrument within different care settings.

Theoretically, respect shown in nurses' being with and doing for patients are inseparable. An interesting finding in this study was that nurses may pay respect to their patients more in thought (Being with) than in deed (Doing for). This result gives support to the findings of Beach et al. 2015 who indicated that treating a person with respect is more than the sum of any set of particular behaviours. However, the

need for future research is suggested on the relationship between being with and doing for a patient in order to verify possible differences between these two parts (Part a and B) of the ReSpect Scale.

It is necessary to know how respect is perceived by older patients when maintaining value–based health care in order to enhance ethical quality in nursing care (DiBartolo 2006, Kalb & O'Conner–Von 2007, Chung 2013). The ReSpect Scale proved to be a valid instrument to measure respect, and to identify deficiences in perceived respect. The VAS from 0 to 100 was used in its entirety. The area with the most need for improvement was that of listening and encouraging. The results of this study indicate that there is a need for preparing for and engaging in empathic and meaningful relationships with patients by noticing patients' views and taking them seriously (supported also by Heliker & Nguyen 2010, Thompson et al. 2011, Jonasson & Berterö 2012, Papastavrou et al. 2012). Further, patients' desire for more participation in decision–making processes was very apparent in this study and this could be done by offering more positive acknowledgement and encouragement in order to strengthen patients' individual capacity to be part of their care (also Kvåle & Bondevik 2008, Jonasson & Berterö 2012, Periyakoil et al. 2013).

The ReSpect Scale proved to be easy to use and short enough to answer. In this study, the scale was used by interviewing older patients face–to–face. It is also possible to use the instrument as a self–rating tool. However, older patients appreciated the presence of the researcher and shared their perceptions openly. Based on the feelings and experiences of the interviewer, the data collection would have taken much longer without this personal contact and the accepted response rate would have been difficult to reach. In future, this is important to consider when conducting research processes with older patients.

In this study, the ReSpect Scale was tested among older patients who were being discharged from hospital, indicating that their health resources were sufficient to manage at home. More research is needed to test the reliability of the ReSpect Scale in different care settings for older people and with those that have several health problems. The use of the ReSpect Scale emphasises that the voices of older patients should be heard and the views of this largest patient group in our health care organisations, should be promoted.

It has been argued that attempts to incorporate operational indicators of respect into a standardised measurement tool might fail to capture the context of the interaction and may only provide a limited and superficial perspective of respect (Browne 1997, 777). In this study, the frequency of respect shown by nurses' being with and doing for their patients could be evaluated from the older patients' point of view and the areas for improvements could be specified. However, this does not describe the whole spectrum of respect, but it does indicate frequency of the respect visible to older patients, as perceived by themselves. As it is a fundamental necessity,

respect perceived by older patients should be prominent in all relationships between patients and nurses.

7.1.3 Evaluating respect and its associated factors as perceived by older patients

Evaluating respect and its associated factors as perceived by patients will help to make respect visible in nursing science and in nursing care and will provide the means to maintain the ethical quality of nursing care.

The results of this study indicated that older patients' perceptions varied and not all patients felt respected. Older patients with a poor health status perceived respect less frequently than patients with a better health status. Earlier research confirmed that patients with mobility difficulties and poor self–care abilities felt they do not receive enough help and were thus disrespected (Hellström & Sarvimäki, Xiao et al. 2008, Moe et al. 2013). The results of this study also indicated that patients who perceived that their health–related needs were being fulfilled, perceived higher levels of respect (also Thompson et al. 2011, Beach et al. 2015, Farley et al. 2014). These results highlight the importance of respect in nurses' attitudes and behaviours when caring for patients with a poor health status. Moreover, the need for skills to find a competent and ethical balance between encouraging patients in their activities and assisting them in required ways, was also called for (also Oosterveld–Vlug et al. 2014).

Based on the results of this study, unsatisfied older patients perceived respect less frequently than satisfied patients (confirmed by Dickert & Kass 2009). Dissatisfaction could be ascribed to personal characteristics or prior poor experiences of nursing care (DeHart et al. 2009) suggesting that discontented patients who make their discontent known could either obtain better care, or they could be treated discourteously (DeHart et al. 2009, Budzova & Ivanova 2011). A strong positive correlation between care satisfaction and perceived respect may also denote that the items measuring respect and satisfaction were perceived to have mutual or overlapping connotations. More detailed testing of associations on element levels is needed. However, it is important to keep in mind that respect communicated by nurses may be able to alleviate the influence of deleterious complications or malpractices in care (Kahn et al. 2015). These factors are important to verify through future studies.

No statistically significant associations between patients' perceptions of being respected by nurses and any of the patients' sociodemographic variables measured in this study was found. This may suggest that respect was equally present in the care of older patients. On the other hand, the generational differences may be present and older people may take a different stand on nursing care than younger people. However, future studies are needed for the verification of these results.

The desire to care for and receive care is powerful and dynamic (Berg et al. 2007). The results of this study (Papers I, II) are in line with earlier literature emphasising that a power imbalance still exists between patients and health care professionals (Calvin et al. 2007, Kvåle & Bondevik 2008) and patients are sensitive to this discrepancy (Nåden & Eriksson 2004, Hellström & Sarvimäki 2007). Inconsistency between nurses' verbal and nonverbal interaction predicted problems in patient–nurse relationships (Hoontrakul et al. 2008, DeHart et al. 2009, Medvene & Lann–Wolcott 2010) as well as nurses' conduct when determining what to do and how to do (Buzgova & Ivanova 2011, Williams & Herman 2011). However, in this study, patients tended to make excuses for nurses and tried to find a balance between asking questions and avoiding disturbing nurses (also Nåden & Eriksson 2004). In the future, older patients may be not so understanding as the present older generation. Complaints concerning patients' treatment, especially communication between patients and health care professionals, have increased recently (Francis 2013, Kahn 2015, Medicolegal Partners 2020).

Respect has been located as a cornerstone of nursing practice for augmenting value–based health care (Thompson et al. 2011), stimulating patients' health (Oosterveld–Vlug et al. 2014) and safeguarding patients' satisfaction with the care they receive (Berglund 2007, Kahn 2015). The results of this study imply that increased respect conveyed by nurses may enhance patients' perceived health status and increase their satisfaction with nursing care. As such, respect conveyed by nurses appears to be a moderator of perceived health and perceived care satisfaction (Paper IV). Future research is needed to verify these associations and to test the ReSpect Scale in relation to other factors e.g. to test the associations between perceived respect and perceived integrity and perceived autonomy.

7.1.4 Summary of discussion of the results

This study analyzed respect in nursing care from older patients' point of view and presented possibilities to measure it. By doing so some solutions for the progression had to be made, as summarized in Figure 5.

First, respect had to be defined in a way that the perceptions of respect could be measured. This was actualised by 1) defining and describing the concept of respect to discover the origin of the concept and its uses in the context of healthcare, 2) specifying the manifestations of respect to obtain a deeper understanding of the concept and the empirical findings, 3) enquiring into the meaning of respect as older patients perceived it in nurses' being with and doing for them.

Secondly, the methods were selected carefully to capture the meaning of respect. This was accomplished by 1) utilising the literature on respect in every phases of this study and by making an aggregation of it in a summary phase, 2) conducting two

open interviews in order to create a theoretical basis of respect as perceived by older patients, 3) conducting two expert panels and a pilot test to develop the ReSpect Scale for the measurement of older patients' perceptions of respect in nurses' being with and doing for them, and 4) conducting a survey to test the newly developed instrument and the factors associated with perceived respect.

In conclusion, it can be stated that to measure an abstract ethical concept such as respect is only possible by defining the concept in a precisely restricted context such as from the point of view of a particular group of people; in this study the context was older patients' perceptions of respect shown by nurses during their care.

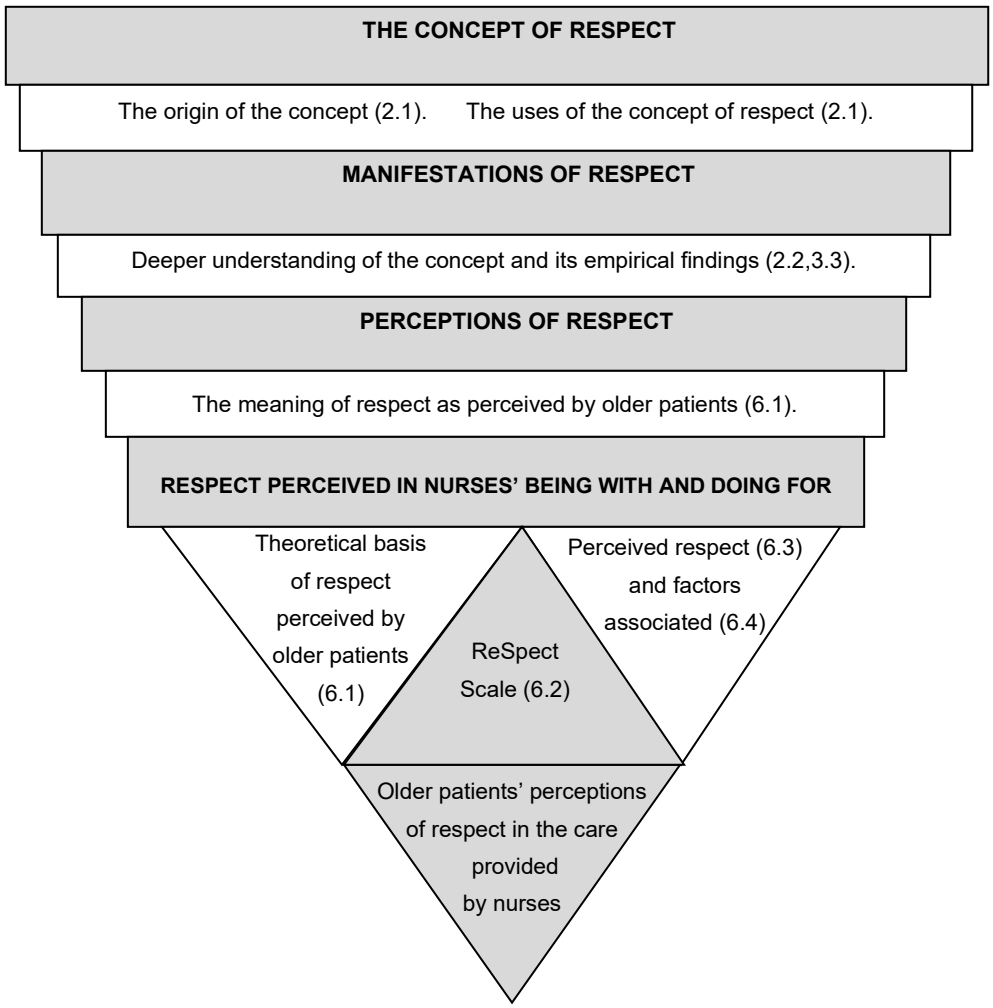

Figure 5. The solutions used in the progression when measuring the ethical concept of respect in nursing care.

7.2 Validity and reliability of the study

Validity and reliability are important cornerstones in assessing the quality of the studies process. Validity determines the reality and accuracy of the research and applies to the phenomenon and the design of the study. Reliability is concerned with the consistency of the information achieved in a study and the methods used to measure the study variables. (Polit & Beck 2012.)

This three–phase study aimed to analyse respect in nursing care as perceived by older patients, and to develop and to test an instrument for its evaluation. In Phase I, two empirical studies with a descriptive and narrative design and individual open interviews of older patients and their next of kin were conducted in order to define and describe respect as perceived by older patients. In Phase II, expert panels and a pilot survey were conducted to develop the ReSpect Scale based on the results of Phase I. In Phase III, a cross–sectional survey with individual interviews was conducted to test the developed scale and its associated factors. Both the theoretical and empirical literature about the concept of respect was utilised in every phases of the study, and the literature review of empirical studies on respect was conducted in the summary phase to aggregate and amalgamate earlier literature reviews made in this study (Sandelowski 2008). This methodological and data source triangulation increased the validity and reliability of the study by providing corroborating evidence from different sources of data to deepen understanding on respect from the perspective of older patients (Moen 2006, Moon 2019).

The following sections discuss the four parts of the validity and reliability of the study. First, the validity of the Phase I is discussed. Second, the validity and reliability of the instruments is discussed, and this is followed by a discussion on the validity related to the research process in Phase III. Finally, the validity of the literature review is discussed.

Validity of the Phase I

In Phase I, the theoretical basis of respect perceived by older patients was developed based on the two interview studies. The rigor of this qualitative study phase was evaluated by establishing the **trustworthiness** of the study by assessing credibility, dependability, conformability, and transferability (Lincoln & Cuba 1985, Holloway & Wheeler 2002, Graneheim & Lundman 2004).

Credibility refers to whether the data are believable, and the results reflect the actual experiences and perceptions of the participants (Graneheim & Lundman 2004). The older people participating in the interviews represented patients cared for in different care settings (hospital, nursing home and home care) who were willing to share their experiences and perceptions (Sugarman et al. 2007, Peel & Wilson

2008). Patients with severe memory disorders where excluded (data II) by using MMSE value ≥ 24 as an inclusion criterion to confirm credibility.

By presenting the questions orally as an open interview any visual or motoric difficulties were reduced (Moore & Hollet 2003, Sugarman et al. 2007, Peel & Wilson 2008.) Furthermore, it was possible to continue the interviews until a sufficient sample size had been reached. Older patients were asked to respond to the questions in the context of the care on the ward where they were being cared for. Some patients reflected on earlier caring periods during the interviews, and it is conceivable that they answered with these memories in mind. Further, some older patients felt awkward about answering some of the questions, not wanting to criticise their nurses while others endeavoured to provide explanations for nurses and their behaviour, which may have biased the results positively (Hall et al. 2009).

Next of kin were chosen by the patients themselves. Older patients and their next of kin were interviewed separately to prevent any influence on each other's answers. The answers given by the next of kin supplemented the patients' answers and made the voice of the patients more powerful. All participants felt they were being listened to and that they had a possibility to be frank, and no one used the option to withdraw, which confirmed the credibility. (Sugarman et al. 2007, Peel & Wilson 2008.)

The **dependability** of the interview studies was supported by carefully describing the means of data collection and the analysis, so that readers can follow the process (Lincoln & Cuba 1985). The open interviews and inductive content analysis (on Data I, II) (Patton 2002, Graneheim & Lundman 2004) following the construction of a typology (on Data II) (Macduff 2007) were found to be an appropriate method to obtain the perspectives of older patients as regards respect in nursing care. The analysis process and the solutions chosen are described step by step in Table 13. Through the whole analysis process, the correspondence between the results and original data was ensured and an adequate number of quotations were presented to demonstrate originality. The use of a second analyst might have increased the dependability of the study (Polit & Beck 2003). This was not achieved due to the practical reasons; however, the results were critically analysed by the research team (Holloway & Wheeler 2002). Further, the dependability of the studies could be increased by returning the results to the respondents for evaluation (Graneheim & Lundman 2004). This was not performed because evaluations could not be gathered from older patients suffering from a decline in their memory (Moore & Hollet 2003).

Conformability refers to research not being subjected to researcher bias or environmental influences (Lincoln & Cuba 1985). Both interviews (Data I, II) were conducted during compact time periods and collected by using a careful data collection protocol devised rigorously by the researcher (Graneheim & Lundman 2004). Before the data collection the researcher became familiar with the methods

of phenomenology presented by Giorgi (Koivisto et al. 2002, Giorgi 2005, Norlyk & Harder 2010) and Colaizzi (1978) to deepen the knowledge obtained from the interviews and to refine the skills necessary to obtain as much profound information on respect as possible from the participants' point of view. In support of the studies' conformability, the researcher conducted all the interviews herself, knew the care environments of the patients and had experience in interviewing older patients, which enhanced the skillful management of the interview situations. Researcher bias was decreased by maintaining a neutral stance throughout the entire research process. Environmental influences were eliminated by interviewing participants in a familiar and quit environment on a day and time chosen by the interviewees.

Transferability refers to whether the research results may be transferred to other settings or groups (Lincoln & Cuba 1985). The results were obtained from relatively small samples (data I, n = 20 and data II, n = 40) and placing them in another context should be viewed with caution. However, the findings of the two interview studies provided a deeper understanding of the experiences of vulnerable older patients and can thus transferred to other situations because the phenomenon of respect is essential and is present all the time in care.

Validity and reliability of the instruments, Phase II–III

In Phase II and III, the ReSpect Scale was developed and tested. The validity and reliability of these phases are next evaluated from the perspective of assessing the accuracy of the measurements (DeVon et al. 2007). The validity refers to the degree of the instrument's ability to measure what it is intended to measure, and the reliability refers to the stability of the measurement (DeVellis 2003, DeVon et al. 2007, Grove et al. 2013). The instruments used were selected carefully based on their high validity and reliability in studies including older patients in various care settings (e.g. Herdman et al. 2011).

In Phase II, the ReSpect Scale was developed inductively based on the results of the Phase I and by utilising the literature. To assess the validity and reliability of the ReSpect Scale, two expert panels were consulted and a pilot study was conducted concerning the scale's *content validity* and *preliminary internal consistency* (DeVellis 2003, DeVon et al. 2007) (Appendix 7.). The content validity of the ReSpect Scale was assessed by the first expert panel (n=10) to enhance the relevance (1 = not relevant – 4 = very relevant) and clarity (1 = not clear – 4 = very clear) of the items by using an 80 % agreement on clarity (Walz et al. 2005). The second expert panel (n = 5) critically re–discussed the modified items (n=33) (DeVon et al. 2007). As a result of the expert panels discussions, similar items were combined, items were specified, and the number of the items was reduced; the final result was a compact scale with a convenient sample of items (n=23) for older people to answer.

The participants on the expert panels (n = 10 and n = 5) were all professionals and experts in nursing ethics.

The preliminary internal consistency reliability of the ReSpect Scale was tested in a pilot study (n = 30) (DeVon et al. 2007) consisting of older hospital patients recruited based on the same inclusion criteria as participants in Phase III. The Cronbach's alpha coefficient for the total scale was 0.98 (n = 30), for its parts 0.95 (A) and 0.98 (B), and for the subscales 0.90–0.97 (criterion ≥ 0.70). The corrected item–total correlations were 0.73–0.96 (criterion r = 0.30 – 0.90) and interitem correlations 0.64–0.92 (criterion r = 0.30 – 0.90) (Rattray & Jones 2007, Grove et al. 2013). These values provided support for the reliability of the ReSpect Scale and indicated that the scale could be used for a cross–sectional study with larger data. Moreover, the pilot study confirmed the clarity of the items, the instructions to participants, and the use of the VAS scale to evaluate the frequency of respect perceived by patients. Some redundant words were deleted, and a few changes in word orders made after the pilot test.

In Phase III, the *internal consistency reliability* (DeVon et al. 2007) was again tested in a cross–sectional study with a larger sample of older hospital patients (n = 196). For the total ReSpect Scale, the Cronbach's alpha coefficient was 0.98, for its parts 0.93 (A) and 0.97 (B), and for the subscales, the values ranged from 0.91 to 0.93; these results indicate a strong intercorrelation of the items (higher than 0.70) and suggest that the items worked well together and the internal consistency reliability for the total scale and its parts were acceptable (Grove et al. 2013). The item–total correlations ranged from 0.78 to 0.91 (criterion r = 0.30–0.90) and the interitem correlations from 0.68 to 0.86 (criterion r = 0.30–0.90) (Rattray & Jones 2007, Grove et al. 2013), which indicates the reliability of the ReSpect Scale to measure respect perceived by older patients in the care provided by nurses. However, high Cronbach's alpha coefficient values may indicate some overlapping in the items and the need for a reassessment as regards redundancy (Grove et al. 2013, Tavakol & Dennic 2011, Taber 2017). However, by deleting items, the breadth and width of the concept might be reduced losing some older patients' descriptions of the concept. Consequently, there is a need for future testing of the ReSpect Scale on older people in different care settings to demonstrate its reliability.

To assess the validity of the ReSpect Scale further, a construct and criterion validity were conducted (DeVellis 2003, DeVon et al. 2007, Polit & Beck 2012). *Construct validity* examines whether the instrument measures the intended con–struct of the study (Polit & Beck 2012), which in this case was respect perceived by older patient. The Principal Component Analysis (PCA) with Promax rotation (Streiner & Nordman 2008, Grove et al. 2013) gave support for the theoretically constructed two factors in part A (Being with) and the four factors in part B (Doing for) explaining 84.5 % – 84.8 % of the variance, respectively. However, in three

subscales the factor loadings divided into two factors indicating that they were too similar and measured the same subject (Table 16.). More testing of the ReSpect Scale is needed to detect whether the sub concepts can be combined and the scale shortened. Nevertheless, only one item in the scale had low communality (criterion <0.40) (DeVellis 2003, DeVon et al. 2007), therefore, overall the number of items and construct validity of the scale was supported to measure respect perceived by older patients in the care provided by nurses. However, in the future, the ReSpect Scale needs more testing to verify the results of this study and to confirm the ReSpect Scale as a valid instrument to measure respect perceived by patients.

Criterion validity reflects the use of a well–established measurement to create a new measurement to measure the same construct, while *concurrent validity* permits confidence in the fact that the two measurement procedures are measuring the same thing (Polit & Beck 2012). The high Pearson's correlation coefficient (r=0.83) between the ReSpect Scale and CBI–RDO provided support for the criterion validity of the ReSpect Scale, indicating that both measurements measure the same phenomenon (Grove et al. 2013.) However, the use of the ReSpect Scale allowed more detailed information to be collected on respect perceived by older patients in nurses' being with and doing for patients; it also identified areas requiring improvements in nursing care, thus increasing the validity of the scale.

In Phase III, two other instruments were also used: The Patient Satisfaction Scale (PSS, Kim 1999), and The EuroQol 5D–5L (EQ–5D–5L, Herdman et al. 2011). These instruments were carefully chosen based on their validity and reliability in other studies including older patients in various care settings (e.g. Herdman et al. 2011). Intercorrelations between the ReSpect Scale total and the PSS (r = 0.75), the EQ–5D–5L index (r = 0.3), and the EQ VAS score (r = 0.15) were all statistically significant indicating that perceived health status and perceived care satisfaction were positively related to perceived respect. More specific examination of the sum scores of the PSS and the EQ–5D index in quartiles (poor, moderate, good, and excellent) indicated a statistically significant difference between poor health status and all other quartiles. This finding provides verification that the ReSpect Scale captures important aspects of nursing care that can be applied to the development of ethics in care delivery. However, more vigorous testing techniques may need to be used to test the ReSpect Scale, and further studies using more strict designs and multi–variate analysis methods are needed to investigate the possible causal associations between the study variables. Future testing of the ReSpect Scale is needed to confirm the results of this study. Moreover, future testing will also be focused on other associations than those tested in this study e.g. perceived integrity or perceived autonomy, both of which will contribute to promoting ethics in nursing care.

Validity related to the research process in Phase III

The validity related to the research process in Phase III and the literature review is next evaluated from the perspectives of the strengths and limitations concerning the *data*, *method*, *analysis,* and *generalisation*. This evaluation considers the process of an open approach to the measurement of the abstract ethical concept of respect (Figure 5.).

The *data* (n = 196) concerned older hospital patients being cared for in two hospitals in an urban area in South–West Finland. The sample size conformed to the methodological literature suggesting that a sufficient sample should be 5–10 times the number of items in the scale (ReSpect Scale, 23 items), that is, around 200 participants (Grove et al. 2013). The data were collected rigorously during a four–month period to decrease the impact of external factors on the integrity of the data, e.g. staff holidays or organisational changes. Further, the data were collected by two researchers (JK/RH), allowing more information to be gathered on using the newly developed instrument. The data collection protocol was carefully devised by the principal investigator (JK) and both interviewers familiarised themselves with the questionnaire together to maximise the standardisation of the data collection procedure. Both interviewers had previous experience of interviewing older patients increasing the validity of the data collection process. Neither interviewers had any influence on the selection of participants. The participants were well informed about the study and the principles of voluntariness and confidentiality were followed. The data were collected on discharge time which may have disturbed some participants' concentration when answering the questions. However, the time for interviews were chosen based on participants wishes, and no one used their option to refuse.

Face–to–face structured interviews with questionnaires were used as a data collection *method* to ensure that any visual or motor difficulties were mitigated (Peel & Wilson 2008), and the calculated sample size attained (Steiner & Norman 2008). The answers to the questions were given orally by the participants and written down by the interviewer which could feasibly lead to a positive bias. Therefore, to reduce any possible bias, the participants' responses were repeated by the interviewers and then noted down under the observation of the participants.

Face–to–face interviews allowed important observations to be made about of the usability of the ReSpect Scale. The ReSpect Scale proved to be easy to use; the instrument was quick (23 items) to use, the questions were compact and understandable, and the VAS scale for the evaluation of the frequency of respect perceived by older patients was felt fascinating. The VAS was illustrated with pictures and colours and discussed before the interview commenced, making the scale suitable for any participants who had a deminished abstract ability or a cognitive disorder (Williamsson & Hoggart 2005). Older patients who have been discharged from hospital could also use the ReSpect Scale as a self–report measure;

this option will be considered in future studies. However, many of the participants appreciated the presence of the investigator and used the opportunity for more discussion on the subject.

Some patients reflected on earlier hospitalisations during the interview, and it is possible that they replied after recalling these memories. Moreover, the questions in the ReSpect Scale may have been felt to be too intimate and critical by some participants. For example, the questions: "Nurses were approving towards me" and "Nurses took my views seriously" made some participants feel uncomfortable as they did not want to criticize their nurses. Other participants endeavoured to make excuses for the nurses and their behaviour, which may have biased the results positively. A positive bias may be reduced by forming the questions in general manner, and by directing them to an overall concern about respect for patients on a ward, for example: "Nurses were approving of their patients" and "Nurses took patients' views seriously", or even more general questions about nursing culture, for example: "Staff were approving of their patients and "Patients' views were taken seriously". This is worth considering as some older patients highlighted the fact that they felt respected by their nurses, but expressed worry and sorrow concerning some of the other patients. In future, the ReSpect Scale could be used in observation studies by modifying the questions to include an observer's perspective. However, the interest of this study was on older patients' perceptions of the respect they perceived in the care provided by their nurses. By making the questions more general may risk losing the personal experiences of respondents. The ReSpect Scale proved to be a useful tool to measure respect, which is an important element of value–based healthcare.

To summarize, the results of this study must be interpreted with caution. The results and associations found in this study are preliminary and not *generalisable* to larger populations. The study was conducted in two Finnish hospitals in one urban area. However, the psychometric properties of the ReSpect Scale gave support to the elements of respect defined in this study, indicating that these elements could be suitably adapted to different caring situations within different age groups of the population. However, the ReSpect Scale requires more testing in the future to verify the results made in this study. Moreover, the Finnish population is homogenous, and in future, it is important to test the ReSpect Scale and to analyse the results in cultures with diverse population and culture backgrounds.

Validity related to the literature review

The literature review was conducted in every phase of this study and the findings aggregated and amalgamated in the summary phase in order to give support to the theoretical basis of respect perceived by older patients and to confirm the elements

of respect in nurses' being with and doing for patients. For the literature searches four databases were used, two of which (Medline and CINAHL) are the most important for bibliographical searches related to nursing care (Subirana et al. 2005). The same search terms were used in all databases and the terms were selected with the help of an expert on database searches. In addition, the grey literature of dictionaries, legislations, care policies, ethical statements, and publications of nursing theories were utilised to formulate a consistent understanding of respect in nurses' being with and doing for patients. (Papers I–IV, summary)

The searches endeavoured to find the central documents and empirical studies concerning respect in nursing care strived to find. All empirical studies defining or describing respect in some ways were selected for the review after a critical comparison with the inclusion criteria by two researchers (JK & RS) (Appendix 1.). However, some pertinent publications may have been descounted. The review included studies that were performed in different countries and cultures and thus present a versatile perspective on general elements of respect in nurses' being and doing. The synthesis of the literature on respect is based on the interpretations of one researcher which may be a limitation of this study (Sandelowski 2008). However, the results and interpretations were carefully discussed within the research team and the theoretical basis of respect developed in this study was based on older patients' authentic experiences and thus supports for the synthesis made in the literature review.

7.3 Suggestions for the future research

According to the results of this study, the following suggestions are highly recommended as areas for future research:

Conceptual clarification

More research with different approaches and methods is needed for the clarification of the concept of respect in nursing care.

1. The manifestation of respect presented in this study can be further investigated, for example, by using an observation technique to confirm the elements of respect found in this study.
2. The theoretical foundation of the manifestation of respect presented in this study, should be developed in the future by investigating respect in next of kin –related actions and in environment–related factors.
3. The manifestation of respect in a patient–nurse relationship can be defined and described from the perspectives of nurses. By analysing different

approaches to respect, the basis for a new theory on respect in nursing science could be created.

Further development and testing of the ReSpect Scale

In the context of nursing care, the ReSpect Scale warrants further testing, modification and translation work. This would strengthen its use in empirical studies.

1. Future testing of the ReSpect Scale is needed to obtain information about its usability in nursing practice and to analyse its sensitivity and specificity. Firstly, the demonstration of its reliability should primarily concentrate on older people in different care settings. Secondly, the need for future psychometric analysis in item separation and sensitivity could be done, for example, by using the Rasch model based on the Item Response Theory. Thirdly, future testing of the scale will elucidate more clearly the relationship between the parts (A and B).
2. Future modifications of the ReSpect Scale and its use in other research samples and from different perspectives will make respect more visible in nursing care. For example, the modification of the ReSpect Scale to the perspective of the patients' next of kin could be done by measuring how the next of kin perceive respect in the older patients' nursing care provided by nurses; or from the perspectives of nurses by measuring in what manner nurses perceive that they are able to convey respect to their patients.
3. Future translation of the ReSpect Scale into different languages and testing of it in different cultures is necessary to gain information on the cultural sensitivity of the scale and to ensure the international research collaboration.
4. Future testing of the ReSpect Scale in relation to other factors associated with perceived respect is required to strengthen the profile of respect in nursing practice, e.g. to test associations between perceived respect and other values and principles in nursing care, e.g. perceived integrity and perceived autonomy.

Advancing respect in nursing care

More research is needed for advancing respect in different fields of nursing care.

1. Developing an educational intervention for nurses on respect and to assess learning outcomes to evaluate whether and to what extent it would be

possible to learn how to show respect. Furthermore, analysing the teaching of respect in nursing education would be important.

2. Testing of nurses' reflection on the elements of respect defined in this study, both in relation to their work satisfaction and professional dedication.
3. Analysing of patient complaints about disrespect and claims of being disrespected to determine what improvements can be made and to develop procedures essential for enhancing respect in nursing care.

7.4 Practical implications

According to results of this study the following practical implications can be presented for nursing practice and administration, nursing science and education, policymaking, and society as whole.

Implications for nursing practice and administration

1. Older patients' perceptions of being respected by nurses needs to be assessed regularly. The ReSpect Scale developed in this study should be included as a means of testing manifested respect in the standard quality assurance and patient safety processes of the organisations.
2. Regularly reflections on the elements of respect shown by nurses that are defined in this study, may increase nurses' understanding of respect in the care delivery from older patients' point of view and lead to more respectful encounters with older people in health care settings.
3. The elements of respect, defined in this study, could also be reflected on and transferred into the relationships between health care professionals. This may also have an impact on respect in nursing cultures and that shown by the leadership, as well as encouraging the maintenance of respectful encounters in workplaces.
4. Increased respect in nurses' being and doing may be a way to improve patients' outcomes, such as perceived health status and increased satisfaction with nursing care.

Implications for nursing science and education

1. More research on respect in nursing care is needed to confirm the results of this study and to strengthen ethics in nursing science and in nursing education.

2. This study offers a theoretical contribution to our understanding of respect in nursing care of older patients.
3. Nurses' consciousness and manifestations of respect ought to be strengthened during basic nursing education and supported by upgraded training on how to enhance respectful encounters in nursing relationships. This could be achieved by developing study modules on respect attitudes, behaviours, and competency with regard to respect.

Implications for policymaking and society

1. This study emphasises respect from older patients' point of view. Older patients in this study frequently felt respected in nursing care, but also expressed important views on improvements. It is essential that respect for older people is included in all political areas of our society and in every policy document, and to confirm its implementation at every level of health care organisations.
2. Clarification of respect and its manifestations may make the ethical principles and recommendations more concrete and support respectful relationships with older people.
3. Respect for older people and ageing needs to be carefully discussed in our society. Positive attitudes towards older people and focusing on their remaining capacities instead of deteriorating health will promote older peoples' perceived respect.

8 Conclusions

This study was inspired by older patients and their experiences of respect in nursing practice. This study gave a voice to older patients, made an abstract ethical concept visible in nursing care and facilitated its identification and measurement. The following conclusions can be drawn from the findings of this study.

Firstly, reflection on the theoretical basis of respect developed in this study will help nurses to find the ways of being with and doing for their patients and to promote patients perceived health and their satisfaction with nursing care.

Secondly, this study introduced the ReSpect Scale by allowing respect to be examined empirically with operational definitions. Future investigations of respect in health care are needed using larger populations and multivariate analyses to test and develop further the theoretical construction and the present view of respect and its associated factors. The ReSpect Scale has relevance for healthcare managers who wish to augment value–based nursing care by using high quality care instruments in healthcare practice.

Thirdly, the findings of this study could be used for developing study modules in nursing education on attitudes to respect, as well as behaviors, and competency. Concentrating on respect in education may lead to improved respectful encounters in health care workplaces.

Finally, this study gives a voice to older patients and makes their perceptions visible. Older people participating in this study had profound and versatile understanding of respect in nursing care and made this study possible with their wise perceptions. The importance of positive attitudes to aging and on older people in our society is emphasised as a means of maintaining ethical quality in all interactions between people and also a way of upholding a culture of respect for others in our welfare society.

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References

Abley C. 2012. Responding to vulnerability in old age: Patient–centred care. Nursing Standard 27, 42–46. doi: 10.7748/ns2012.10.27.9.42.c9384.

Aboumatar H, Beach MC, Yang T, Branyon E, Forbes L, Sugarman J. 2015. Measuring patients' experiences of respect and dignity in the intensive care unit: a pilot study. Narrative Inquiry in Bioethics 5, 69A–84A. doi.org/10.1353/nib.2015.0005.

Act on the Status and Rights of Patients 785/1922. 1992. Ministry of Social Affairs and Health, Finland. Retrieved from https://www.finlex.fi/en/laki/kaannokset/1992/en19920785_20120690.pdf (15.4.2020)

All European Academies, ALLEA. 2017. The European code of Conduct for Research Integrity. Retrieved from https://www.allea.org/wp–con–tent/uploads/2017/05/ALLEA–European–Code–of–Conduct–for–Research–Integrity–2017.pdf (15.8.2018)

ANA. 2015. View the code of ethics for nurses. American Nurses Association. Retrieved from https ://www.nursingworld.org/practice–policy/nursing–excellence/ethics/code–of–ethics–for–nurses/ (24.11.2018)

ANA 2016. The Nurse's Role in Ethics and Human Rights: Protecting and Promoting Individual Worth, Dignity, and Human Rights in Practice Settings. Retrieved from https://www.nursingworld.org/~4af078/globalassets/docs/ana/ethics/ethics–and–human–rights–protecting–and–promoting–final–formatted–20161130.pdf (16.4.2020)

Anderberg P, Lepp M, Berglund A–L, Segesten K. 2007. Preserving dignity in caring for older adults: a concept analysis. Journal of Advanced Nursing 59, 635–43. doi.org/10.1111/j.1365–2648.2007.04375.x.

Arcand M, Monette J, Monette M, Sourial N, Fournier L, Core B, Bergman H. 2008. Educating nursing home staff about the progression of dementia and the comfort care option: Impact on family satisfaction with end–of–life care. Journal of the American Medical Directors Association 10(1), 50–55. doi: 10.1016/j.jamda.2008.07.008.

Ausserhofer D, Zander B, Busse R, Schubert M, De Geest S, Raffer–ty AM., … Schwendimann R. 2013. Prevalence, patterns and predictors of nursing care left undone in European hospitals: Results from the multicountry cross-sectional RN4CAST study. BMJ Quality and Safety 23, 126–135. doi.org/10.1136/bmjqs–2013–002318.

Baillie L. 2009. Patient dignity in an acute hospital setting: a case study. International Journal of Nursing Studies 46(1), 22–37. doi: 10.1016/j.ijnurstu.2008.08.003.

Baillie L, Ford P, Gallagher A, Wain–wright P. 2009. Nurses' views on dignity in care. Nursing Older People 21, 22–9. doi: 10.7748/nop2009.10.21.8.22.c7280.

Bayer T, Tadd W, Krajcik, S. 2005. Dignity: The voice of older people. Quality in Ageing and Older Adults 6, 22–29. doi: 10.1108/14717794200500005.

Beach MC, Forbes L, Branyon E, Aboumatar H, Carrese J, Sugarman J, Geller G. 2015. Patient and family perspectives on respect and dignity in the Intensive Care Unit. Narrative Inquiry in Bioethics 5(1A), 15–25.

Beauchamp TL, Childress FC. 2013. Principles of biomedical ethics. 7th edition. Oxford University Press, New York.

Berg L, Skott, C, Danielson E. 2007. Caring relationship in a context: Fieldwork in a medical ward. International Journal of Nursing Practice 13, 100–106. doi: 10.1111/j.1440–172X.2007. 00611.x.

Berglund AL. 2007. Satisfaction with caring and living conditions in nursing homes: Views of elderly persons, next of kin and staff members. International Journal of Nursing Practice 13, 46–51. doi.org/10.1111/j.1440–172X.2006. 00602.x.

Berterö C, Ek AC. 1993. Quality of life of adults with acute leukaemia. Journal of Advanced Nursing 18, 1346–1353. doi.org/10.1046/j.1365–2648.1993. 18091346.x.

Birrel J, Thomas D, Jones CA. 2006. Promoting privacy and dignity for older patients in hospital. Nursing Standard 20, 41–46. doi.org/10.7748/ns2006.01.20.18.41.c4037.

Bolz M, Parke B, Shuluk J. Capezuti E, Galvin JE. 2013. Care of older adult in the emergency depart–ment: Nurses views of the pressing issues. The Gerontologist 53(3), 441–453. doi.org/10.1093/geront/gnt004.

Bourbonnais A, Ducharme F. 2010. The meanings of screams in older people living with dementia in a nursing home. International Psychogeriatrics 22, 1172–84. doi.org/10.1017/S1041610209991670.

Bowersox N, Bohnert A, Ganoczy D, Pfeiffer P. 2013. Inpatient psychiatric care experience and its relationship to posthospitalization treatment participation. Psychiatric Services 64, 554–562. doi: 10.1176/appi.ps.002342012.

Bridges J, Flatley M, Meyer J. 2010. Older people's and relatives' experiences in acute care settings: systematic review and synthesis of qualitative studies. International Journal of Nursing Studies 47, 89–107. doi:10.1016/j.ijnurstu.2009.09.009).

Brilowski GA, Wendler MC. 2005. An evolutionary concept analysis of caring. Journal of Advanced Nursing 50(6), 641–650. doi.org/10.1111/j.1365–2648.2005.03449.x.

Browne A. 1993. A conceptual clarification of respect. Journal of Advanced Nursing 18, 211–217. doi.org/10.1046/j.1365–2648.1993. 18020211.x.

Browne A. 1995. The meaning of respect: A First Nations perspective. Canadian Journal of Nursing Research 27, 95–109.

Browne A. 1997. A concept analysis of respect applying the hybrid model in cross–cultural settings. Western Journal of Nursing Research 19, 762–80. doi.org/10.1177/019394599701900605.

Brunton B, Beaman M. 2000. Nurse practitioners' perceptions of their caring behaviors. Journal of the American Academy of Nurse Practitioners 12(11), 451–456. doi.org/10.1111/j.1745–7599.2000.tb00153.x.

Buzgova R, Ivanova K. 2009. Elder abuse and mistreatment in residential settings. Nursing Ethics 16, 110–126. doi.org/10.1177/0969733008097996.

Buzgova R., Ivanova K. 2011. Violation of ethical principles in institutional care for older people. Nursing Ethics 18, 64–78. doi.org/10.1177/0969733010385529.

Calvin AO, Frazier L, Cohen MZ. 2007. Examining older adults' perceptions of health care providers. Genetics and Gerontology 33(5), 6–12. doi.org/10.3390/ijerph17197056.

Can G, Akin S, Aydiner A, Ozdilli K, Durna, Z. 2008. Evaluation of the effect of care given by nurs–ing students on oncology patients' satisfaction. European Journal of Oncology Nursing 12, 387–392. doi: 10.1016/j.ejon.2008.02.004.

Charter of Fundamental Rights. 2010. Charter of fundamental rights of the European Union. Retrieved from http://eur–lex.europa.eu/LexUriServ/LexUriServ.do? uri¼OJ:C: 2010:083:0389:0403: EN:PDF (6.1.2014).

Chung G. 2013. Understanding nursing home worker conceptualizations about good care. Gerontologist 53, 246–254. doi: 10.1093/geront/gns117.

Ciemins EL, Brant J, Kersten D, Mullette E, Dickerson D. 2015. A qualitative analysis of patient and family perspectives of palliative care. Journal of Palliative Medicine 18(3), 282–285. doi: 10.1089/jpm.2014.0155

Collaizzi P. 1978. Psychological research as the phenomenologist views it. In the work of Valle R, King M (ed). Existential–phenomenological alternatives for psychology. Oxford University Press, New York, 48–71.

Cooper JR, Mitchell PF. 2004. Nursing in the aged care arena: Perceptions of the experienced gerontic nurse. Contemporary Nurse 16(3), 169–177.

Coventry ML. 2006. Care with dignity: A concept analysis. Journal of Gerontological Nursing 32, 42–48. doi: 10.3928/00989134–20060501–08.

D'Antonio P, Beeber L, Naegle M. 2014. The future in the past: Hildegrad Peplau and interpersonal relations in nursing. Nursing Inquiry 21(4), 311–317. doi: 10.1111/nin.12056.

DeHart D, Webb J, Cornman C. 2009. Prevention of elder mistreatment in nursing homes: Compe–tencies for direct–care staff. Journal of Elder Abuse & Neglect 21, 360–378. doi.org/10.1080/08946560903005174.

DeLellis AJ. 2000. Clarifying the concept of respect: Implications for leadership. The Journal of Leadership Studies 7(2), 35–49. doi.org/10.1177/107179190000700203.

Denzin NK, Lincoln YS. 2005. The SAGE Handbook of Qualitative Research. 5th edition. Thousand Oaks, California.

DeVellis RF. 2003. Scale Development, Theory and Applications. 2nd edition. SAGE, Thousands Oaks, CA, USA.

DeVon HA, Block ME, Moyle–Wright P, Ernst DM, Hayden SJ, Lazzara DJ, Savoy SM, Kostas–Polston E. 2007. A psychometric toolbox for testing validity and reliability. Journal of Nursing Scholarship 39(2), 155–164. doi: 10.1111/j.1547–5069.2007.00161.x.

Dewin J. 2004. Concerns relating to the application of frameworks to promote person–centredness in nursing with older people. Journal of Clinical Nursing 13, 39–44. doi: 10.1111/j.1365–2702.2004.00925.x.

DiBartolo MC. 2006. Respect and dignity: Enduring concepts, enduring challenges. Journal of Geronto–logical Nursing 32, 12.

Dickert NW, Kass NE. 2009. Understanding respect: Learning from patients. Journal of Medical Ethics 35, 419–423. doi.org/10.1136/jme.2008.027235.

Dillon RS. 1992. Respect and care: Toward moral integration. Canadian Journal of Philosophy 22, 105–132. 10.1080/00455091.1992.10717273.

Dillon RS. 2007. Respect: A philosophical perspective. Gruppendynamik und Organisationsberatung 38(2), 201–212. doi: 10.1007/s11612–007–0016–538.

Dillon RS. 2018. Respect. Retrieved from https://plato.stanford.edu/archives/spr2018/entries/respect/. (16.4. 2020)

Downie R, Telfer E. 1969. Respect for persons. Schocken Books, New York.

Downie RS, Calman KC, Schrock R, Macnaughton M. 1994. Healthy respect: Ethics in health care. 2nd edition. Oxford University Press, New York.

Duffy JD, Hoskins L, Seifert RF. 2007. Dimensions of caring. Psychometric evaluation of the Caring Assessment Tool. Advances in Nursing Science 30, 235–245. doi: 10.1097/01.ANS.0000286622.84763.a9.

EC, European Commission. 2007. Healthy ageing a challenge for Europe. Retrieved from http://www.healthyageing.eu/sites/www. healthyage–ing.eu/files/resources/Healthy%20Ageing%20–%20A%20Challenge%20for%20Europe.pdf (20.9.2018)

EC, European Commission. 2007. Healthy ageing: keystone for a sustainable Europe. EU health policy in the context of demographic change. Retrieved from http://ec.europa.eu/health/archive/ph_information/indicators/docs/healthy_ageing_en.pdf (9.1.2012)

EC, European Commission. 2007. White paper. White paper on sport. Retrieved from http://ec.europa.eu/sport/white–paper/the–2007–whitepaper–on–sport_en.htm (9.1.2012)

Emsfors Å, Christensson L, Elgan C. 2017. Nursing actions that create a sense of good nursing care in patients with wet age–related magular degeneration. Journal of Clinical Nursing 26, 2680–2688. doi: 10.1111/jocn.13749.

ETENE 2001. Shared values in health care, common goals and principles. Retrieved from https://etene.fi/documents/1429646/1571616/Publication+3+Shared+values+in+Health+Care%2C+Common+Goals+and+Principles%2C+2001.pdf/10bdd2be–c322–48c2–a143–4e11ebc9235f/Publication+3+Shared+values+in+Health+Care%2C+Common+Goals+and+Principles%2C+2001.pdf (3.6.2020)

ETENE, The National Board on Social Welfare and Health Care Ethics. 2019. Tutkimuksen eettinen arvionti Suomessa. Retrieved from https://www.tenk.fi/stes/tenk.fi/files/Ihmistieteiden_eettisen_ennakkoarvioinnin_ohje_2019.pdf (13.4.2020)

European Commission. 2007. Healty ageing: keystone for a sustainable Europe. EU health policy in the context of demographic change. Retrieved from https://ec.europa.eu/health/ph_information/indicators/docs/healthy_ageing_en.pdf (13.4.2021)

European Commission. 2013. Ethics for researchers. Retrieved from https://ec.europa.eu/research/partici–pants/data/ref/fp7/89888/ethics–for–researchers_en.pdf (6.4.2020)

EuroQol Group. 1990. EuroQol – A new facility for the measurement of health-related quality of life. Health Policy 16, 199–208. doi: 10.1016/0168–8510(90)90421–9.

EuroQoL Group. 2015. EQ-5D-5L User Guide Basic information on how to use the EQ-5D-5L in–strument. Retrieved from https ://euroq ol.org/wpcontent/uploa ds/2016/09/EQ–5D–5L_UserG uide_2015.pdf (4.9.2018)

Evers C, Ploeg J, Kaasalainen S. 2011. Case study of the attitudes and values of nursing students toward caring for older adults. Journal of Nursing Education 50(7), 404–409.

Ferri P, Muzzalupo J, Di Lorenzo R. 2015. Patients' perception of dignity in an Italian general hospital: A cross–sectional analysis. BMC Health Service Research 28, 41. doi: 10.1186/s12913–015–0704–8.

Finch LP. 2006. Patients' communication with nurses: relational cammunication and preferred nurse behaviors. International Journal for Human Caring 10(4), 14–22. doi: 10.20467/1091–5710.10.4.14.

Finlex 2007. National Pension Act 568/2007. Retrieved from https://www.finlex.fi/fi/laki/ajantasa/2007/20070568 (26.3.2021)

Foronda CL. 2008. A concept analysis of cultural sensitivity. Journal of Transcultural Nursing 19, 207–212. doi.org/10.1177/1043659608317093.

Francis R. 2013. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. The Stationery Office, London

Fry S, Johnstone MJ. 2008. Ethics in nursing practice. A guide to ethical decision making. 3rd edition. Blackwell Publishing, Oxford, UK.

Gallagher A, Seedhouse D. 2002. Dignity in the care: the views of patients and relatives. Nursing Times 98(43), 38–40. doi: 10.1016/j.ijnurstu.2008.08.003.

Gallagher A. 2004. Dignity and respect for dignity – two key health professional values: Implications for nursing practice. Nursing Ethics 11, 587–599. doi: 10.1191/0969733004ne744oa.

Gallagher A. 2007. The respectful nurse. Nursing Ethics 14, 360–371. doi.org/10.1177/0969733007075874.

Gallagher A, Li S, Wainwright P, Jones IR, Lee D. 2008. Dignity in the care of older people – a review of the theoretical and empirical literature. BMC Nursing 7, 1–12. doi.org/10.1186/1472–6955–7–11.

Gastmans C. 1999. Care as a moral attitude in nursing. Nursing Ethics 6(3), 214–222. doi: 10.1177/096973309900600304.

Giorgi A. 2005. The phenomenological movement and research in the human science. Nursing Science Quartely 18(1), 75–82. doi.org/10.1177/0894318404272112.

Graneheim UH, Lundman B. 2004. Qualitative content analysis in nursing research: concepts, proce–dures and measures to achieve trustworthiness. Nurse Education Today 24: 105–12. doi.org/10.1016/j.nedt.2003.10.001.

Greenberg LS. 2004. Being and doing: Person–centeredness, process guidance and differential treat–ment. Person–Centered and Experiential Psychotherapies 3(1), 52–64. doi.org/10.1080/14779757.2004.9688329.

Grove SK, Burns N, Gray J. 2013. The practice of nursing research: Appraisal, synthesis, and gener–ation of evidence. 7th edition. Elsevier Saunders, St. Louis.

Hall S, Longhurst S, Higginson I. 2009. Challenges to conducting research with older people living in nursing homes. BMC Geriatrics 9, 38. doi:10.1186/1471–2318–9–3810.

Hall S, Dodd RH, Higginson IJ. 2014. Maintaining dignity for residents of care homes: A qualitative study of the views of care home staff, community nurses, residents and their families. Geriatric Nursing 35, 55–60. doi: 10.1016/j.gerinurse.2013.10.012.

Hallström I, Elander G. 2001. Need during hospitalization: Definitions and descriptions made by pa–tients. Nursing Ethics 8, 409–418. doi: 10.1177/096973300100800505.

Hansebo G, Kihlgren M. 2002. Careers' interactions with patients suffering from severe dementia: A difficult balance to facilitate mutual togetherness. Journal of Clinical Nursing 11, 225–236. doi: 10.1046/j.1365–2702.2002. 00601.x

Harrison R, Walton M, Healy J, Smith-Merry J, Hobbs C. 2016. Patient complaints about hospital ser–vices: Applying a complaint taxonomy to analyse and respond to complaints. International Journal for Quality in Health Care, 28, 240–245. doi.org/10.1093/intqhc/mzw003.

Heiselman T, Noelker LS. 1991. Enhancing mutual respect among nursing assistants, residents and res–idents' families. The Gerontologist 31(4), 552–555. doi.org/10.1093/geront/31.4.552.

Heliker D, Nguyen HT. 2010. Story sharing: Enhancing nurse aide–resident relationships in long–term care. Research in Gerontological Nursing 3, 240–252. doi: 10.3928/19404921–20100303–01.

Hellström UW, Sarvimäki A. 2007. Experiences of self–determination by older persons living in shel–tered housing. Nursing Ethics 14, 413–424. doi.org/10.1177/0969733007075888.

Henderson V. 1966. The Nature of Nursing: A definition and its implications for practice, research, and education. Macmillan, NY.

Herdman M, Gudex C, Lloyd A, Janssen MF, Kind P, Parkin D, … Badia X. 2011. Development and preliminary testing of the new five-level version of EQ-5D (EQ-5D-5L). Quality of Life Research 20, 1727–1736. doi.org/10.1007/s11136–011–9903–x.

Hernandez G, Garin O, Dima AL, Pont A, Pastor MM, Alonso J, Van Gance E, Laforest L, de Bruin Marijn, Mayoral K, Serra–Sutton V, Ferrer M. 2019. EuroQol (EQ–5D–5L) Validity in assessing the Quality of Life in adults with asthma: cross–sectional study. Journal of Medical Internet Research 21, 1–12. doi: 10.2196/10178.

Holmberg, M, Valmari G, Lundgren S. 2012. Patients' experiences of homecare nursing: Balancing the duality between obtaining care and to maintain dignity and self–determination. Scandinavian Journal of Caring Sciences, 26, 705–712. doi: 10.1111/j.1471–6712.2012. 00983.x

Holloway I, Wheeler S. 2002. Qualitative research in nursing. 2nd edition. Blackwell Publishing Company, Oxford.

Hoontrakul D, Sritanyarat W, Nuntaboot K, Premgamone A. 2008. Development of age–friendly pri–mary health care: Case study of one primary care unit. Thai Journal of Nursing Research 12(2) 131–141.

Hsu M–Y, McCormack B. 2010. The experience of applying a narrative research approach with older people. Journal of Nursing Research 18(4), 249–257. doi: 10.1097/JNR.0b013e3181fc669e.

Hubbard G, Downs MG, Tester S. 2003. Including older people with dementia in research: challenges and strategies. Aging & Mental Health 7(5), 351–362. doi: 10.1080/1360786031000150685.

Hwang H–L, Hsieh P–F, Wang H–H. 2013. Taiwanise long–term care facility residents' experiences of caring: a qualitative study. Scandinavian Journal of Caring Sciences 27, 695–703.

ICN, International Council of Nurses. 2012. The ICN code of ethics for nurses. Retrieved from http://www.icn.ch/who–we–are/code–of–ethics–for–nurses/ (13.4.2018)

Jacelon CS. 2004. Managing personal integrity: the process of hospitalization for elders. Journal of Advanced Nursing 46(5), 549–557. doi.org/10.1111/j.1365–2648.2004.03029.x.

Jacelon CS, Connelly TW, Brown R, Proulx K, Vo T. 2004. A concept analysis of dignity for older adults. Journal of Advanced Nursing 48, 76–83.

Jakobsen R, Sorlie V. 2010. Dignity of older people in a nursing home: narratives of care providers. Nursing Ethics 17: 289–300. doi.org/10.1177/0969733009355375.

Johansson P, Oleni M, Fridlund B. 2002. Patient satisfaction with nursing care in the context of health care: A literature study. Scandinavian Journal of Caring Sciences 16, 337–344. doi.org/10.1046/j.1471–6712.2002.00094.x.

Jonasson LL, Liss PE, Westerlind B, Berterö C. 2010. Ethical values in caring encounters on a geriat–ric ward from the next of kin's perspective: An interview study. International Journal of Nursing Practice 16, 20–26. doi: 10.1111/j.1440–172X.2009. 01805.x

Jonasson LL, Berterö C. 2012. The importance of 'approaching' older people: A grounded theory. In–ternational Journal of Older People Nursing 7, 29–36. doi.org/10.1111/j.1748–3743.2010. 00248.x.

Jones K. 2004. Mission drift in qualitative research, or moving toward a systematic review of qualitative studies, moving back to a more systematic narrative review. The Qualitative Report 9, 95–112. doi.org/10.46743/2160–3715/2004.1939.

Kahn SA, Iannuzzi JC, Stassen NA, Bankey PE, Gestring M. 2015. Measuring satisfaction: Factors that drive hospital consumer assessment of healthcare providers and systems survey responses in a trauma and acute care surgery population. The American Surgeon 81, 537–543.

Kalankova D, Kirwan M, Bartonickova D, Cubelo F, Ziakova K, Kurucova R. 2020. Missed, rationed or unfinished nursing care: A scoping review of patient outcomes. Journal of Nursing Management 28(8), 1783–1797. doi.org/10.1111/jonm.12978.

Kalb KA, O'Conner–Von S. 2007. Ethics education in advanced practice nursing: Respect for human dignity. Nursing Education Perspectives 28, 196–202.

Kelly B. 1990. Respect and caring: Ethics and essence of nursing. In Ethical and moral dimensions of care (Leininger MM. Ed.), Ethical and moral dimensions of care. Wayne State University Press, Detroit.

Kim HS. 1991. Patient-Nurse collaboration in nursing care decision making: American studies. In International nursing research conference, nursing research: Global health perspectives. American Nurses Association and Council of Nurse Researchers, Los Angeles.

Koivisto K, Janhonen S, Väisänen L. 2002. Applying a phenomenological method of analysis derived from Giorgi to a psychiatric nursing study. Journal of Advanced Nursing 39(3), 258–265. doi.org/10.1046/j.1365–2648.2002.02272.x.

Koskenniemi J, Stolt M, Hupli M, Suhonen R, Leino–Kilpi H. 2014. Muistipotilaan haastattelu – haaste klinikoille ja tutkijoille. Tutkiva hoitotyö 12(1), 4–11. In Finnish.

Kvåle K, Bondevik M. 2008. What is important for patient centred care? A qualitative study about the perceptions of patients with cancer. Scandinavian Journal of Caring Sciences, 22, 582–589. doi: 10.1111/j.1471–6712.2007. 00579.x

Körner M, Ehrhardt H, Steger AK. 2013. Designing an interprofessional training program for shared decision making. Journal of Interprofessional Care 27, 146–154. doi.org/10.3109/13561820.2012.711786.

Lee–Hsieh J, Turton MA. 2004. Patient experiences in the development of a caring code for clinical nursing practice. International Journal for Human Caring 8(3), 21–29. doi: 10.20467/1091–5710.8.3.22.

Leino–Kilpi H. 1990. Good Nursing Care – On What Basis? Annales Universitatis Turkuensis D 49. Fin–land: University of Turku.

Leino–Kilpi H. 1992. Basis of the quality of nursing care. A short quantitative description. Scandinavian Journal of Caring Sciences 6, 139–146. doi: 10.1111/j.1471–6712. 1992.tb00140.x

Leino–Kilpi H, Välimäki M, Dassen T, Gasull M, Lemonidou C, Scott PA, … Koljonen A. 2003. Per–ceptions of autonomy, privacy and informed consent in the care of elderly people in five European countries: Comparison and implications for the future. Nursing Ethics 10, 58–66. doi.org/10.1191/0969733003ne575oa.

Levine M. 1997. Nursing ethics and the ethical nurse. American Journal of Nursing 77(5), 846–847. doi.org/10.2307/3461709.

Lincoln YS, Guba EG. 1985. Naturalistic Inquiry. Sage Publications Inc, London.

Macduff C. 2007. Typologies in nursing: a review of the literature. Nurse Researcher 14(2), 40–50. doi: 10.7748/nr2007.01.14.2.40.c6020.

Mayeroff M. 1971. On caring. 1st edition. Perennial Library, Harper and Row, New York.

McCormack B, McCance T. 2006. Development of framework for person–centred nursing. Journal of Advanced Nursing 56, 472–479. doi.org/10.1111/j.1365–2648.2006.04042.x.

Medicolegal Partners. 2020. Key findings from the Francis Report. Retrieved from https://www.medicolegal–partners.com/2020/01/28/the–francis–report–key–findings/ (16.5.2021)

Medvene LJ, Lann–Wolcott H. 2010. An exploratory study of nurse aids' communication behaviours: Giving positive regards as a strategy. International Journal of Older People Nursing 5, 41–50. doi: 10.1111/j.1748–3743.2009. 00183.x

Moe A, Hellzen O, Enmarker I. 2013. The meaning of receiving help from home nursing care. Nurs–ing Ethics 20, 737–747. doi: 10.1177/0969733013478959.

Moen T. 2006. Reflections on the narrative research approach. International Journal of Qualitative methods 5(4), 56–69. doi.org/10.1177/160940690600500405.

Molloy DW, Alemayehu E, Roberts R. 1991. Reliability of a standardized Mini–Mental State Exami–nation compared with the traditional Mini–Mental State Examination. American Journal of Psychiatry 148, 102–5. doi: 10.1176/ajp.148.1.102.

Moon MD. 2019. Triangulation: a method to increase validity, reliability, and legitimation in clinical research. Journal of Emergency Nursing 45(1), 103–105. doi.org/10.1016/j.jen.2018.11.004.

Moore TF, Hollet J. 2003. Giving voice to persons living with dementia: the researcher's opportunities and challenges. Nursing Science Quality 16, 163–167. doi: 10.1177/089431840325179325179 3.

MOT Oxford Dictionary of English. 2005. Retrieved from https://mot–kielikone–fi.ezproxy.utu.fi/mot/turkuyo/netmot.exe (19.9.2018)

MOT Oxford Thesaurus dictionary. 2009. Retrieved from https://mot–kielikone–fi.ezproxy.utu.fi/mot/turkuyo/netmot.exe (19.9.2018)

MSAH, Ministry of Social Affairs and Health.2018. Quality recommendation to guarantee a good quality of life and improved services for older persons 2017–2019. Retrieved from http://julkaisut.valtioneuvosto.fi/bit–stream/handle/10024/160688/STM_J_01_2018.pdf (3.4.2020)

MSAH, Ministry of Social Affairs and Health 2020. Laatusuositus hyvän ikääntymisen turvaamiseksi ja palvelujen parantamiseksi 2020–2023: Tavoitteena ikäystävällinen Suomi. Sosiaali– ja terveysministeriön julkaisuja 2020:29. Retrieved from http://urn.fi/URN:ISBN:978–952–00–5457–1 (3.2.2020)

NMC, Nursing & Midwifery Council 2013. NMC response to the Francis report. The response of the Nursing and Midwifery Council to the Mid Staffordshire NHS Foundation Trust Public Inquiry report. Retrieved from https://www.nmc.org.uk/globalassets/sitedocuments/francis–report/nmc–response–to–the–francis–report–18–july.pdf, (6.4.2021)

Nolan MR, Davies S, Brown J, Keady J, Nolan J. 2004. Beyond 'person–centred' care: A new vision for gerontological nursing. Journal of Clinical Nursing 13, 45–53. doi. org/10.1111/j.1365–2702.2004.00926. x.

Norlyk A, Harder I. 2010. What makes a phenomenological study phenomenological? An analysis of peer–reviewed empirical nursing studies. Advancing Qualitative Methods 20(3), 420–431. doi.org/10.1177/1049732309357435.

Nåden D, Eriksson K. 2004. Understanding the importance of values and moral attitudes in nursing care in preserving human dignity. Nursing Science Quarterly 17, 86–91. doi: 10.1177/0894318403260652.

OECD, Organisation for Economic Co–operation and Development. 2020. Health at a Glance: Europe 2020. Retrieved from https://www.oecd.org/health/health–at–a–glance–europe/ (3.4.2021)

Oosterveld–Vlug MG, Pasman HR, van Gennip IE, Willems DL, Onwuteaka–Philipsen BD. 2013. Nursing home staff's views on residents' dignity: A qualitative interview study. BMC Health Services Research 16, 353. doi: 10.1186/1472–6963–13–353.

Oosterveld-Vlug MG, Pasman HR, van Gennip IE, Muller MT, Willems DL, Onwuteaka-Philipsen BD. 2014. Dignity and the factors that influence it according to nursing home residents: A qualitative interview study. Journal of Advanced Nursing 70, 97–106. doi.org/10.1111/jan.12171.

Palese A, Tomietto M, Suhonen R, Efstathiou G, Tsangari H, Merkouris A, … Papastavrou E. 2011. Surgical patient satisfaction as an outcome of nurses' caring behaviors: A descriptive and correlational study in six European countries. Journal of Nursing Scholarship; Indianapolis 43, 341–350. doi.org/10.1111/j.1547–5069.2011.01413. x.

Papastavrou E, Efstathiou G, Tsangari H, Suhonen R, Leino–Kilpi H, Patiraki E, … Merkouris A. 2012. Patients' and nurses' perceptions of respect and human presence through caring behaviours: A comparative study. Nursing Ethics 19, 369–379. doi: 10.1177/0969733011436027.

Patton MQ. 2002. Qualitative Research & Evaluation Methods. 3rd edition. Sage Publications, London.

Peel NM, Wilson C. 2008. Frail older people as participants in research. Educational Gerontology 34, 407–417. doi.org/10.1080/03601270701835973.

Peplau HE. 1997. Peplau's theory of interpersonal relations. Nursing Science Quarterly 10, 162–167. doi: 10.1177/089431849701000407.

Percival J, Johnson M. 2013. End–of–life care in nursing and care homes. Nursing Times 109, 20–22.

Periyakoil VS, Stevens M, Kraemer H. 2013. Multicultural long–term care nurses' perceptions of fac–tors influencing patient dignity at the end of life. Journal of American Geriatric Sociology 61, 440–446. doi: 10.1111/jgs.12145.

Person A, Finch L. 2009. Bedside manner: Concept analysis and impact on advanced nursing practice. The International Journal of Advanced Nursing Practice 10(1), 1–7.

Pesonen H–M, Remes AM, Isola A. 2011. Ethical aspects of researching subjective experiences in early–stage dementia. Nursing Ethics 18(5), 651–661. doi.org/10.1177/0969733011408046.

Polit DF & Beck CT. 2012. Nursing Research: Generating and Assessing Evidence for Nursing Practice. 9th edition. Lippincott, Williams & Wilkins, Philadelphia.

Randers I, Mattiasson A–C. 2004. Autonomy and integrity: upholding older adult patients' dignity. Journal of Advanced Nursing 45(1), 63–71. doi: 10.1046/j.1365–2648.2003.02861.x.

Rattray J, Jones MC. 2007. Essential elements of questionnaire design and development. Journal of Clinical nursing 16(2), 234–243. doi: 10.1111/j.1365–2702.2006.01573.x.

Reader TW & Gillespie A 2013. Patient neglect in healthcare: a systematic review and conceptual model. BMW Health Services Research, 13, 156. doi:10.1186/1472–6963–13–156.

Reader TW, Gillespie A, Roberts J. 2014. Patient complaints in healthcare systems: A systematic review and coding taxonomy. BMJ Quality and Safety 23, 678–689. doi.org/10.1136/bmjqs.2013–002437.

Robichaud L, Durand PJ, Bedard R, Ouellet J–P. 2006. Quality of life indicators in long–term care: opinions of elderly residents and their families. Canadian Journal of Occupation Therapy 73, 245–51. doi: 10.2182/cjot.06.003.

Ryan EB, Hamilton JM, See SK. 1994. Patronizing the old: How do younger and older adults respond to baby talk in the nursing home? International Journal of Ageing and Human Development 39(1), 21–32.

Sandelowski M. 2008. Reading, writing and systematic review. Journal of Advanced Nursing 64(1), 104–110. doi.org/10.1111/j.1365–2648.2008.04813.x.

Sanakirja.org. Retrieved from https://www.sanakirja.org/search (15.9.2018)

Scherwin S, Winsby M. 2010. A relational perspective on autonomy for older adults residing in nursing homes. Health Expectations 14, 182–190. doi: 10.1111/j.1369–7625.2010. 00638.x

Smith KV. 2005. Ethical issues related to health care: the older adult's perspective. Journal of Geronto–logical Nursing 31(2), 32–39. doi.org/10.3928/0098–9134–20050201–08.

Solin H. 1984. Hippokrateen vala. Hippokrates, Suomen Lääketieteen Historian Seuran vuosikirja, pages 12–17.

Solum E, Slettebø A, Hauge S. 2008. Prevention of unethical actions in nursing homes. Nursing Eth–ics 15, 536–48. doi: 10.1177/0969733008090524.

Song L, Hamilton H, Moore AD. 2012. Patient–healthcare provider communication: perspectives of African American cancer patients. Health Psychology 31(5), 539–547. doi: 10.1037/a0025334.

Spichiger E. 2010. Patients' and families' experience of their relationship with professional healthcare providers in hospital end–of–life care. International Journal of Palliative Nursing 12, 194–202. doi: 10.1097/NJH.0b013e3181d4c20b.

Standard Dictionary of English language. 1970. International Edition. Funk & Wagnalls, New York.

Streiner DL, Norman GR. 2008. Health Measurement Scales, a practical guide to their development and use. 4th edition. Oxford University Press, New York.

Ström M, Baigi A, Hildingh C, Mattsson B, Marklund B. 2011. Patient care encounters with the MCHL: a questionnaire study. Scandinavian Journal of Caring Sciences 25, 517–524. doi.org/10.1111/j.1471–6712.2010.00858.x

Subirana M, Sola I, Garcia JM, Gich I, Urrutia G. 2005. A nursing qualitative systematic review required MEDLINEand CINAHL for study identification. Journal of Clinical Epidemiology 58(1), 20–25. doi: 10.1016/j.jclinepi.2004.06.001.

Sugarman J, Roter D, Cain C, Wallace R, Schmechel D, Welsh–Bohmer KA. 2007. Proxies and consent discussions for dementia research. Journal of American Geriatric Society 55, 556–561. doi: 10.1111/j.1532–5415.2007.01101.x.

Suhonen R. 2002. Individualised care from the surgical patient's point of view – Developing and testing a model. Annales Universitatis Turkuensis D 523. Finland: University of Turku.

Suhonen R, Leino-Kilpi H, Välimäki M, Kim HS. 2007. The Patient Satisfaction Scale – An empirical investigation into the Finnish adaption. Journal of Evaluation in Clinical Practice 13, 31–38. doi.org/10.1111/j.1365–2753.2006.00643. x.

Suhonen R, Papastavrou E, Efstathiou G, Tsangari H, Jarosova D, Leino-Kilpi, H, … Merkouris A. 2012. Patient satisfaction as an outcome of individualised nursing care. Scandinavian Journal of Caring Sciences 26, 372–380. doi.org/10.1111/j.1471–6712.2011. 00943.x.

Suhonen R, Stolt M, Berg A, Katajisto J, Lemonidou C, Patiraki, E, … Charalambous A. 2018. Cancer patients' perceptions of quality–of-care attributes – Associations with age, perceived health status, gender and education. Journal of Clinical Nursing 27, 306–316. doi.org/10.1111/jocn.13902.

Swanson KM. 1991. Empirical development of a middle range theory of caring. Nursing Research 40(3), 161–166. doi.org/10.1097/00006199–199105000–00008.

Taber KS. 2017. The use of Cronbach's alpha when developing and reporting research instruments in science education. Research in Science Education 48, 1273–1296. doi: 10.1007/s11165–016–9602–2.

Talier DS. 2004. Beyond caring: the moral and ethical bases of responsive nurse–patient relationship. Nursing Philosophy 5, 230–241. doi: 10.1111/j.1466–769X.2004.00182.x.

Tavakol M, Dennick R. 2011. Making sense of Cronbach's alpha. International Journal of Medical Education 2, 53–55. doi: 10.5116/ijme.4dfb.8dfd.

Teeri S, Leino–Kilpi H, Välimäki M. 2006. Long–term nursing care of elderly people: Identifying ethi–cally problematic experiences among patients, relatives and nurses in Finland. Nursing Ethics 13, 116–129. doi.org/10.1191/0969733006ne830oa.

Teeri S, Välimäki M, Katajisto J, Leino–Kilpi H. 2008. Maintenance of patients' integrity in long–terminal institutional care. Nursing Ethics 15, 523–535. doi: 10.1177/0969733008090523.

TENK, Finnish Advisory Board on Re–search Integrity. 2012. Responsible conduct of research and procedures for handling allegations of misconduct in Finland. Guidelines of the Finnish Advisory Board on Research Integri–ty. Retrieved from https://www.tenk.fi/sites/tenk.fi/files/HTK_ohje_2012.pdf (15.4. 2020)

The Universal Declaration of Human Rights. 1948. Retrieved from https://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf (15.4.2020)

Thompson IE, Melia KM, Boyd KM, Horsburgh D. 2006. Nursing Ethics. 5th edition. Churchill Livingstone, Elsevier, London.

Thompson GN, McClement SE, Chochinov HM. 2011. How respect and kindness are experienced at the end of life by nursing home residents. Canadian Journal of Nursing Research 43, 96–118.

TUKIJA, National Committee on medical research ethics. 2011. Operating procedures of the national committee on medical research ethics. Retrieved from https://tukija.fi/documents/1481661/1546647/TUKIJA_toimintaohje_ENG_11102016.pdf/760e4687–85a2–4f05–956c–2667e863a3ef/TUKIJA_toimintaohje_ENG_11102016.pdf (3.4.2020)

United Nations 1948. The Universal Declaration of Human Rights. Retrieved from https://www.un.org/en/universal–declaration–human–rights/index.html (6.3.2021)

van Hout B, Janssen MF, Feng YS, Kohlmann T, Busschbach J, Golicki D, Lloyd A, Scalone L, Kind P, Pickard AS. 2012. Interim scoring for the EQ–5D–5L: mapping the EQ–5D–5L to EQ–5D–3L value sets. Value in Health 15(5), 708–715. doi.org/10.1016/j.jval.2012.02.008.

Verbeek H, Meyer G, Leino–Kilpi H, Zabalequi A, Rahm Hallberg I… Hamers JPH & RightTimePlaceCAre Consortium. A European study investigating patterns of transition from home care towards institutional dementia care: the protocol of a RightTimePlaceCare study. BMC Public Health 12, 68. Retrieved on https://link.springer.com/content/pdf/10.1186/1471–2458–12–68.pdf (3.4.2021)

Välimäki M. 1998. Self–determination in psychiatric patients. Annales Universitatis Turkuensis D 288. Finland, University of Turku.

Välimäki M, Leino–Kilpi H, Scott PA, Arndt M, Dassen T, Lemonidou C, … Cabrera E. 2001. The role of CNSs in promoting elderly patients' autonomy in long–term institutions: Problems and im–plications for nursing practice and research. Clinical Nurse Specialist 15, 7–14. doi:10.1097/00002800–200101000–00009.

Wainwright P, Gallagher A. 2008. On different types of dignity in nursing care: a critique of Nor–denfelt. Nursing Philosophy 9, 46–54. doi.org/10.1111/j.1466–769X.2007.00329.x.

Wattles J. The golden rule. 1996. Oxford University Press, New York.

Waltz CF, Strickland OL, Lenz ER. 2005. Measurement in nursing and health research. 3rd edition. Springer Publishing Company, New York.

Watson J. 1985. Nursing: Human science and human care, a theory of nursing. 6th edition. Appleton–Century–Crofts, Norwalk, CT.

Watson J. 2008. Nursing: The Philosophy and Science of Caring. Revised edition. University Press of Colorado, Boulder.

Watson R, McKenna H, Cowman S, Keady J. 2008. Nursing Research: Designs and Methods. 1st edition. Churchill Livinstone, London.

Welford C, Murphy K, Wallace M, Casey D. 2010. A concept analysis of autonomy for older people in residential care. Journal of Clinical Nursing 19, 1226–1235. doi.org/10.1111/j.1365–2702.2009.03185.x.

Westin L, Danielsson E. 2007. Encounters in Swedish nursing homes: a hermeneutic study of resi–dents' experiences. Journal of Advanced Nursing 60, 172–80. doi: 10.1111/j.1365–2648.2007.04396. x.

Whitbread L. 2008. The concept of respect in a resident–centred environment. Perspectives 32, 17–25.

WHO, World Health Organization. 2002. Active ageing: a policy framework. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/67215/WHO_NMH_NPH_02.8.pdf;jsessionid=E3A45962B1DF59ADE52C196FDFE49AF7?sequence=1 (3.4.2020)

WHO, World Health Organization. 1994. A declaration on the promotion of patients' rights in Europe. Re–trieved from https://www.who.int/genomics/pub–lic/eu_declaration1994.pdf?ua=1 (13.12.2019)

WHO, World Health Organization. 2015. World report on ageing and health. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811_eng.pdf?sequence=1 (26.4.2020)

WHO, World Health Organization. 2021. Global Report on Ageism. Retrieved from www.who.int/teams/social–determinants–of–health/demographic–change–and–healthy–ageing/combatting–ageism/global–report–on–ageism (3.4.2021)

Williams KN. 2006. Improving outcomes of nursing home interactions. Research in Nursing & Health 29, 121–133. doi: 10.1002/nur.20117.

Williams KN, Herman RE. 2011. Linking resident behaviour to dementia care communication: effects of emotional tone. Behavior Therapy 42, 42–46. doi: 10.1016/j.beth.2010.03.003.

Williamsson A, Hoggart B. 2005. Pain: A review of three commonly used pain rating scales. Journal of Clinical Nursing 14, 798–804. doi: 10.1111/j.1365–2702.2005. 01121.x

WMA, World Medical Association. 2013. Declaration of Helsinki – Ethical principles for Medical Re–search Involving Human Subjects. Retrieved from https://www.wma.net/policies–post/wma–declaration–of–helsinki–ethical–principles–for–medical–research–involving–human–subjects/ (6.4.2020)

Wolf ZR, Miller PA, Devine M. 2003. Relationship between nurse caring and patient satisfaction in patients undergoing invasive cardiac procedures. Medsurg Nursing: Official Journal of the Academy of Medical–Surgical Nurses 12, 391–396.

Wolf ZR, Zuzelo PR, Goldberg E, Croters R, Jacobson N. 2006. The Caring Behaviors Inventory for elders: Development and psychometric characteristics. International Journal of Human Caring 10(1), 49–59.

Wu Y, Larrabee J, Putnam H. 2006. Caring Behaviors Inventory. A reduction of the 42–item instrument. Nursing Research 55, 18–25. doi.org/10.1097/00006199–200601000–00003.

Xiao H, Barber JP. 2008. The effect of perceived health status on patient satisfaction. Value in Health 11, 719–725. doi.org/10.1111/j.1524–4733.2007.00294. x.

Appendices

Appendix 1. Empirical studies included in literature review on respect in nursing care of older patients (n=44).

Author, year, country	Purpose	Setting, sample	Method, analysis	Respect– related findings
Arcand et al. 2008 Canada	To assess the impact on family satisfaction with end–of–life care of a nursing home pilot educational programme for professionals on comfort care and advanced dementia.	Nursing home, 27/21 relatives	Pre–post intervention followed by phone interviews Statistical analysis	Patients were treated with respect and kindness more frequently after the intervention than before it. Treating patients with respect increased patient satisfaction with nursing care.
Bayer et al. 2005 UK	To explore how older people view human dignity in their lives.	Population based study, 391 older people from 6 European countries	Focus groups and individual interviews Thematic analysis	Respect was reciprocal: to receive respect an individual needs to demonstrate it towards others. Respect was lacking when older people's opinions, experience and wisdom were not asked for or valued. Being ignored, humiliated, or violated eroded self–respect.
Beach et al. 2015 USA	To explore the definition of respect and dignity, and the specific behaviours that demonstrate them.	Hospital care, ICU, 21 participants together (patients and families)	Interview Thematic analysis	To be treated with respect had to do with: being treated as an individual, as a family/friend, as an equal, and as important and valuable. Behaviours demonstrating treatment with respect were a caring manner, listening and responsiveness; attention to appearance, information giving and using the patient's family as an information source.
Berg et al. 2007 Sweden	To investigate the caring relationship between patients and nurses.	Hospital care, medical ward 51 patients, 10 nurses	Participant observation and field notes	Respect in the caring relationship was formed by having a mutual positive regard between patients and nurses. This was based on certain attitudes that took seriously everything discussed,

Author, year, country	Purpose	Setting, sample	Method, analysis	Respect– related findings
			Interpretive phenomenological method	allowed for patients' participation and self–determination, and made it possible, at the same time to receive support and be strengthened.
Bertero & Ek 1993 Sweden	To describe what quality of life means to adults with acute leukaemia.	Hospital care, 8 oncology patients	Interviews Inductive analysis	Respect was one of the qualities of the concept of quality of life. Respect reflected the importance of being accepted as me, a human being, an individual capable of taking responsibility for everything in my surroundings. Respect was closely tied to receiving information and having conversations with authentic presence and interest.
Bolz et al. 2013 USA	To describe nurses' views of the issues to be addressed to improve care of the older adult in the emergency department.	Hospital care, emergency department, 527 registered nurses	Responses to the open–ended question: "What are the most pressing issues you currently face in caring for older adults? Content analysis	Lack of respect for older adults had to do with poor communication, lack of information, inadequate support for decision making, and not acknowledging families.
Bourbonnais & Ducharme 2010 Canada	To explore the meanings of older people screaming when living with dementia and the influencing factors on screaming.	Nursing home, 7 triads (patients, family and formal caregivers)	Participant observation Ethnographic analysis	Respect in the way of "being with" older persons by acknowledging their personality, wishes and needs had significant repercussions on the screaming of dementia patients.
Bowersox et al. 2013 USA	To identify factors related to satisfaction with inpatient psychiatric treatment and post discharge mental health participation.	Hospital care, inpatient psychiatric care, 7408 veterans	The Survey of Healthcare Experiences of Patients (inpatient version) (I–SHEP)	Respect and caring by nurses were identified as one of the three domains of patient satisfaction with care. Respect was evaluated as listening carefully, being courteous, appreciating patients' views, caring about patients as

Author, year, country	Purpose	Setting, sample	Method, analysis	Respect– related findings
			Statistical analysis	individuals, and explaining things in an understandable way.
Brunton & Beaman 2000 USA	To explore nurse practitioners' perceptions of their own caring behaviour.	Different care settings, 140 nurse practitioners	40–item Caring Behavior Inventoory (CBI) Statistical analysis	A respectful deference of others and the assurance of a human presence were the most frequently reported dimensions by nurse practitioners. Showing respect (M=5.83, max 6.0) was frequently a secondary reported caring behaviour.
Buzgova & Ivanova 2011 Czech Republic	To investigate the extent and form of elder abuse.	Nursing home, 488 clients, 454 employees	Structured interviews with clients concerning abuse and caring satisfaction, questionnaires for employees concerning abuse and burnout. Statistical analysis	The principle of respect for a person was most frequently violated by forms of psychological and physical abuse. The forms of psychological abuse were not being seen, violations of personal space, and violation of autonomy; the forms of physical abuse were, for example, violation of autonomy by excessive use of physical restraints.
Calvin et al. 2007 USA	To describe older adults' conversations about their relationships with care providers.	Home care, Independent or assisted care, 23 Citizens	Focus group Thematic analysis	Respectful dialogue was important in establishing trust. It was comprised of active listening, undivided attention, a friendly attitude, and a having good bedside manners and a reverent tone of voice.
Can et al. 2008 Turkey	To evaluate the effect of care given by nursing student on patients' satisfaction.	Hospital care, 54 oncology patients	The Oncology Patients' Perceptions of the Quality of Nursing Care Scale–Short Form (OPPQNCS–SF) Statistical analysis	Respect shown by nurses belongs to the responsiveness part of the scale measuring oncology patients' perceptions of the quality of nursing care. Patients were the most pleased with the respect they were shown (5.74, max 6.0).

Author, year, country	Purpose	Setting, sample	Method, analysis	Respect– related findings
Chung 2012 USA	To explore conceptualizations about good care from care workers' perspectives.	Nursing home, 21 nursing assistants	Interview Grounded theory analysis	Respect in the care delivery process included: to knock on a door, to present oneself, to talk to residents, to explain care activities, to ask permission before acting. Respect built rapport, helped to get to know the resident and to notice their moods and emotional downturns.
Ciemins et al. 2015 USA	To explore patient and family satisfaction with palliative care services.	Different palliative care settings, 12 interviews (patients alone or with family member)	Interview Deductive and inductive analysis identifying themes, Atlas.ti software	Respect was mentioned as one of 12 health care professional's competencies linked to satisfaction with palliative care services that were aimed at maintaining patient–centred attributes in nursing care, like presence, reassurance, and honouring choices.
Cooper & Mitchell 2004 Australia	To describe experiences of gerontic nurses on care provided for older persons.	Nursing home, 5 experienced gerontic nurses	Interview, Thematic analysis	Respect is demonstrated by conveying a sense of really being there with older patients. This "caring with" rather than "caring for" is an enabler of self–care and empowering when it fosters patient control, identity maintenance and capacity.
DeHart et al. 2009 USA	To draft competencies essential for caregiver training to prevent mistreatment.	Nursing home, 20 professionals	Interview, ATLAS.ti, grounded–theory analytic approach	Respect related competences preventing mistreatment were associated with verbal and nonverbal communication strategies, strategies to engage patients in their own care, identification of age–related conditions and generational issues, knowing the patient as an individual, and being aware of core caring values including a concern for humanity, compassion, and empathy.

Author, year, country	Purpose	Setting, sample	Method, analysis	Respect– related findings
Emsfors et al. 2017 Sweden	To identify and describe nursing actions performed by nurses that create a sense of good nursing caring patients with age–related macular degeneration	Hospital care 16 patients	Semi–structured interviews Critical incident technique	Being respectful means that patients were invited to participate in conversation about their current health condition. Nurses were calm and competent and had pleasant and friendly manners. Disrespectful nurses were stressed, dominant or irritated. They were superior and treated patients as inferior.
Evers et al. 2011 Canada	To explore nursing students' attitudes and values toward caring for older adults.	Nursing home, 51 nursing students	Online survey and interview, Facts on Ageing Quiz 1 (FAQ1) Thematic analysis	Respect was identified as a value and an ideal for how to treat others.
Finch 2006 USA	To examine nurse–patient communication dimensions and to identify patient–preferred nurse behaviours.	Different care settings, 25 elderly residents, 25 college students and 50 elderly people	The Health Communication interview, Qualitative strategy of the hermeneutic circle Nurse–Patient Communication Assessment Tool (NPR–CAT), statistical analysis	Patient–preferred nurses were respectful practitioners who were genuinely interested in their patients and wanted to consider their feelings and experiences. Respectful nurses found a balance between being warm and friendly and demonstrating caring and sincerity while maintaining professional interpersonal communication with their patients in a competent manner. Nurses affective (attitudes of caring, being understanding, friendly and rapport), cognitive (knowledge, competence) and behavioural (professional actions and skills) responses were each important to patients and their relational communication with nurses.

Author, year, country	Purpose	Setting, sample	Method, analysis	Respect– related findings
Hansebo & Kihlgren 2002 Sweden	To study carers' interactions with patients suffering from dementia, and to investigate changes in their interactions as a result of the intervention.	Nursing home, 4 carers and 9 patients	Intervention study using phenomenological–hermeneutic approach to illuminate video–recorded interactions	Respect for patients was to see the unique person. It was characterized by kindness, politeness, and invitations to participate in the activity. Respect was shown by expressions of humility and sensitivity when asking about patients' opinion and wishes, and approval before acting. Respect for the person was seen in attempts to find a balance between intimacy and distance, to identify when patients need assistance to accomplish an activity.
Heiselman & Noelker 1991 USA	To enhance mutual respect among staff, residents, and families.	Nursing home, 40 nursing assistants (NA) and 37 residents	Semi structured interviews with closed– and open–ended items Statistical analysis Content analysis	Most residents felt that respect was shown by NAs when they were gentle and enjoyed helping residents. About half of the residents were critical of the NAs' behaviours as regards being sensitive and responsive to the residents' feelings. About half of the NAs reported verbal abuse, and insults on behalf of residents and their families.
Hellström & Sarvimäki 2007 Sweden	To describe older patients' experiences of self–determination and being valued as human beings.	Nursing home, 11 sheltered home residents	Interview Content analysis	Respect was related to receiving the help the residents need. Disrespect was related to situations when residents asked for help for but were denied it or made to wait for a long time. Respect varied from one professional to another. Respect was important to self–confidence, and lack of it created feelings of depression.
Holmberg et al. 2012	To describe patients' experiences and perceptions of receiving	Home care, 21 patients	Interview	Patients' experiences had to do with obtaining care and, at the same time, maintaining dignity, integrity, and self–

Author, year, country	Purpose	Setting, sample	Method, analysis	Respect– related findings
Sweden	nursing care in their private homes.		Interpretative description analysis	determination. Being a person meant to be respected as a unique individual: being recognised as individuals, being paid interest in, being talked to and listened to, and having opportunities to talk about daily living in human–to–human communications.
Hoontrakul et al. 2008 Thaimaa	To develop age–friendly primary health care (AFPHC).	Hospital care, primary health care unit, 22 older people, 4 family members, 8 nurses, 10 health care volunteers, 2 leaders of community committees	Observation, interview, focus group, document review Content analysis	Respect for older people was characterised as recognising them politely, valuing their cultural habits (OBS: cultural differences exist in the use of kinship terms), conveying warm and kind verbal and nonverbal expressions (e.g. listening, believing, being sensitive and understanding).
Hwang et al. 2013 Taiwan	To elucidate the nature of caring from older residents' point of view	Nursing home, 12 residents	Semi–structure interviews Content analysis	Respect was shown by initiating caring conversations with residents and valuing their autonomy. Showing respect for autonomy was demonstrated by advocating on residents' behalf, not judging their preferences, and allowing them to make choices.
Jonasson & Berterö 2012 Sweden	To identify ethical values in caring encounters between patients and nurses as experienced by older patients.	Hospital care, stroke and rehabilitation ward, 22 older patients	Observation following interview Constant comparative analysis using grounded theory	Receiving respect had to do with nurses' caring attitude considering patients in a holistic way and giving them possibilities to make choices.

Author, year, country	Purpose	Setting, sample	Method, analysis	Respect– related findings
Jonasson et al. 2010 Sweden	To identify ethical values in interactions with nurses caring for elderly patients as experienced by next of kin.	Hospital Geriatric clinic, 14 next of kin	Interview Constant comparative analysis using grounded theory	Showing respect was a caring act presenting ethical values. It was exhibited in both body and verbal language and appeared in nurses' actions. By listening with interest to patients, allowing next of kin to take part, and by asking questions made it possible to achieve a deeper understanding.
Kvåle & Bondevik 2008 Norway	To investigate cancer patients' perceptions of the importance of being respected as partners and share control of decisions over their health problems.	Hospital, 20 oncology patients	Interview Giorgi's phenomenology analysis	Nurses acts that gave patients the feeling of being treated with respect were: to treat patients as individuals, to take patients seriously, to listen to patients and to encourage them to express their wishes, to listen to their questions and always give an answer, and to do something extra to help patients.
Lee–Hsieh & Turton 2004 Taiwan	To explore patients' experiences and perceptions of caring by nurses.	Hospital, medical–surgical unit, 14 patients	Interview Constant comparative method	Six major themes were assessed to describe caring by nurses: assistance during admission, professional behaviours, communication, empathy, sincerity, and respect. Respect was expressed as a need to be valued as a unique person with individual customs, habits, and religious beliefs; to be protected from exposure of intimate body areas or privileged information; and to be addressed properly and not being criticised behind one's back.
Medvene & Lann–Wolcott	To identify communication behaviours and strategies used by nurse aids working	Nursing home and residential home,	Interview	Respect in communication behaviours had to do with "giving positive regard" by verbal (e.g. greetings, giving

Author, year, country	Purpose	Setting, sample	Method, analysis	Respect– related findings
2010 USA	with residents in long–term care facilities.	16 nursing aides	Directed content analysis	compliment, being friendly), nonverbal (e.g. giving affectionate, smiles, taking time) and other (e.g. learn likes/dislikes) means.
Nåden & Eriksson 2004 Norway	To discuss values and moral attitudes in nursing care from the patients' perspectives.	Hospital, 30 patients	Interview Phenomenological and hermeneutic analysis	Four values that were important to integrate as part of nursing care were: respect, responsibility, fairness, and a thoroughly moral attitude. To be respected by nurses was to be believed, to be heard and taken seriously, to be understood and to receive help. Genuineness and responsibility were presuppositions for the demonstration of respect, and the manifestation of a genuine attitude. Nurses preserve human dignity and worth both in the patients and themselves by realising values and moral attitudes in nursing practice.
Oosterveld–Vlug et al. 2013 Netherlands	To investigate staff's experiences on preserving residents' dignity.	Nursing home, 13 physicians 15 nurses	Interview Thematic analysis	Treating residents with respect entailed caring for residents according to residents' wishes, having little chats with them, and taking them seriously.
Oosterveld–Vlug et al. 2014 Netherlands	To investigate residents' experiences on personal dignity and factors that either preserve or undermine it.	Nursing home, 30 residents	Interviews Thematic analysis	Respect shown by nurses could preserve or undermine residents' dignity.
Papastavrou et al. 2012 Cyprus	To examine the differences in the perceived frequency of respect and human presence in the clinical care	Hospital, surgical general ward 1537 patients	Survey Caring Behaviours Inventory (CBI)–24	Nurses reported fulfilling respectful deference to others more frequently than patients perceived. Patients perceived respect more frequently on

Author, year, country	Purpose	Setting, sample	Method, analysis	Respect– related findings
	between nurses and patients.	1148 nurses	Statistical analysis	the negative side of the scale than those of nurses.
Periyakoil et al. 2013 USA	To examine the perceptions of multicultural long–term care nurses about patient dignity at the end of life (EOL).	Nursing home and residential home, 45 nurses 26 residents	Survey Dignity Card Sort Tool (DCT), Dignity Assessment Survey (DAS) (10 open–ended question tools), NVivo 7 – qualitative– software analysis, statistical analysis	Treating patients with respect and honouring their choices were the most important factors when fostering patient dignity. Respect was characterised as honouring patients' wishes and choices and providing verbal and nonverbal reverential care (by listening, caring, being present, understanding, and helping).
Percival & Johnson 2013 England	To explore the factors influencing good–quality EOL care in nursing homes.	Nursing home, 73 residents 97 staff members 16 relatives	Interview Focus groups Phone interview Analysis not mentioned.	Respect was shown when staff was solicitous and thoughtful. Respect for patients was shown by putting residents at ease, using politely phrases (e.g. "excuse my hand"), informing resident of the task and its purpose, and acknowledging and attending to cultural differences.
Robichaud et al. 2006 Canada	To identify the interpersonal and environmental characteristics for the best substitute living environment.	Long–term care facilities, 19 residents 8 family caregivers	Interview NUDIST – qualitative software analysis	The three most important quality of life indicators were related to humanization in nursing care and interpersonal characteristics: being treated with respect, sympathetic involvement in relationships, and perceived competency through nursing acts and attitudes. Being treated with respect was to respond to residents' needs, interests, habits, and capacities.
Ryan et al.	To examine the meanings of baby– talk between care	Nursing home,	Taped conversations, the response booklet	Caregivers using baby talk speech were rated as significantly less respectful and

Author, year, country	Purpose	Setting, sample	Method, analysis	Respect– related findings
1994 Canada	providers and residents in nursing home.	71 older people 80 students	Statistical analysis	less competent than their peers who used a more neutral language style.
Smith 2005 USA	To investigate every day ethical issues from the perspective of older adult health care consumers.	Different long–term care settings, 5 residents 5 older persons living at home	Interview Content analysis	Respect–related ethical issues were: care providers are obligated to show patients' preferences (desires), time (their choices of how to spend time) and dignity (deference of participants as individuals of worth).
Song et al. 2012 USA	To explore African American cancer patients' perspectives of HCPs' communication behaviours and how these communication patterns facilitate or hinder their cancer management and survivorship experiences.	Hospital, 28 oncology patients	Qualitative interviews Grounded theory techniques of constant comparison	Respect was shown in professionals' communication when they used salutations, appreciated patients' knowledge about their own illness, expressed sensitivity towards the patients' health level, and showed regard for patients' religious beliefs and practices.
Ström et al. 2011 Sweden	To investigate users' satisfaction with the medical care help line (MCHL)	Different care setting and medical care help line, 509 callers (92 over 65 years)	Phone interview Questionnaire Statistical analysis	Respect between the nurse and the patient during the telephone dialogue was a remarkable factor when assessing users' satisfaction with the medical care help line.
Thompson et al. 2011 Canada	To examine factors associated with respect and kindness in the last month of life as a nursing home resident.	Nursing home, 208 family members	Interview Phone interview Questionnaires After–Death Bereaved Family Member Interview,	The key factors influencing whether respect was shown were communication, information–sharing, and meeting residents' personal care needs. Male relatives were more liable than female relatives to infer that the resident was not always treated with respect. Significant for respect was

Author, year, country	Purpose	Setting, sample	Method, analysis	Respect– related findings
			Nursing Facility Family Satisfaction Questionnaire Statistical analysis	family member's /resident's active role in decision–making.
Williams & Herman 2011 USA	To explore the effects of the emotional tone of nursing staff on residents' resistiveness to care (RTC).	Nursing home, 20 naïve raters, student volunteers, aged 18–47	Videotapes Emotional Tone Rating Scale (ETRS), Resistiveness to Care Scale (RTCS) Statistical analysis	Disrespect was felt in the communications of staff conveying high levels of control (e.g. dominating, controlling, bossy and directive).
Williams 2006 USA	To test the effectiveness of an educational intervention to improve nursing staff–resident communication.	Nursing home, 38 staff 60 residents	Pre–post–Intervention Emotional Tone Rating Scale (ETRS), Psycholinguistic measurements Statistical analysis	Infantilising speech was felt to be disrespectful. The use of family requested nicknames were appropriate, however, generalising pet names to all residents crossed a line between respect and disrespect.

Appendix 2. Settings, informants, and study designs of the empirical studies reviewed (n=44).

	Settings				Informants				Study designs			
Refererence	Longterm care	Hospital care	Several settings	Other	Older patients	Nursing staff	Next of kin	Other	**Qual	**Non–exp descriptive	**Non–exp desc+corr	Intervention
Heiselman & Noelker 1991	x				x	x			x	x		
Bertero & Ek 1993		x			x				x			
Ryan et al. 1994	x							NS* C*		x		
Brunton & Beaman 2000			x			x				x		
Hansebo & Kihlgren 2002	x				x	x						x
Cooper & Mitchell 2004	x					x			x			
Lee–Hsieh & Turton 2004		x			x				x			
Nåden & Eriksson 2004		x			x				x			
Bayer et al. 2005				S*	x			C*	x			
Smith 2005			x		x				x			
Finch 2006			x		x			NS*	x	x		
Robichaud et al. 2006	x				x		x		x			
Williams 2006	x				x	x						x
Berg et al. 2007		x			x	x			x			
Calvin et al. 2007				HC*				C*	x			
Hellström & Sarvimäki 2007	x				x				x			
Arcand et al. 2008	x						x					x

	Settings				Informants				Study designs			
Refererence	Longterm care	Hospital care	Several settings	Other	Older patients	Nursing staff	Next of kin	Other	**Qual	**Non–exp descriptive	**Non–exp desc+corr	Intervention
Can et al. 2008		x			x						x	
Hoontrakul et al. 2008		x			x	x	x	PM*	x			
Kvåle & Bondevik 2008		x			x				x			
DeHart et al. 2009	x					x		PM*	x			
Bourbonnais & Ducharme 2010	x				x	x	x		x			
Jonasson et al. 2010		x					x		x			
Medvene & Lann–Wolcott 2010	x					x			x			
Buzgova & Ivanova 2011	x				x	x					x	
Evers et al. 2011	x							NS*	x	x		
Thompson et al. 2011	x						x				x	
Ström et al. 2011			x					C*		x		
Williams & Herman 2011	x				x	x					x	
Chung 2012	x					x			x			
Holmberg et al. 2012				HC*	x				x			
Jonasson & Berterö 2012		x			x				x			
Papastavrou et al. 2012		x			x	x					x	
Song et al. 2012		x			x				x			
Boltz et al. 2013		x				x			x			

	Settings				Informants				Study designs			
Refererence	Longterm care	Hospital care	Several settings	Other	Older patients	Nursing staff	Next of kin	Other	**Qual	**Non–exp descriptive	**Non–exp desc+corr	Intervention
Bowersox et al. 2013		x			x						x	
Hwang et al. 2013	x				x				x			
Oosterveld–Vlug et al. 2013	x					x			x			
Percival & Johnson 2013	x				x	x	x		x			
Periyakol et al. 2013	x				x	x				x		
Oosterveld–Vlug et al. 2014	x				x				x			
Beach et al. 2015		x			x		x		x			
Ciemins et al. 2015			x		x		x		x			
Emsfors et al. 2017		x			x				x			

*HC=Homecare; S=Society; NS=Nurse student; PM=Policy maker; C=Citizen.

**Qual=Qualitative; Non–exp=Non–experimental; Desc=Descriptive; Cor= Correlational

Appendix 3. Example of information letter for the head ward nurses in hospital rehabilitation ward (related to Data I collection)

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15.5.2009

ARVOISA ORTOPEDISEN KUNTOUTUSOSASTON HOITAJA

Suoritan maisteriopintoja Turun hoitotieteellisessä tiedekunnassa ja teen opinnäytetyötä siitä, miten **iäkäs lonkkamurtumapotilas ja hänen lähiomaisensa kokevat arvostuksen toteutuvan erikoissairaanhoidon osastolla**. Haastattelen potilaita ja heidän omaisiaan joko osastolla tai kotiutumisen jälkeen heidän kodeissaan.

Teidän apuanne ja asiantuntemustanne tarvitsen **sopivien haastateltavien** löytämiseksi. Haastateltavien ikäihmisten tulee olla **> 75–vuotiaita lonkkamurtumapotilaita**, joiden leikkaus on suoritettu **Turun yliopistollisessa keskussairaalassa**. Lisäksi heidän tulee olla **suomenkielisiä** ja heiltä edellytetään **verbaalista kykyä** kommunikoida. Vakavista muistihäiriöistä ja sekavuudesta kärsivät potilaat rajataan tutkimuksen ulkopuolelle. Tarkoituksena olisi haastatella myös lähiomaista. Ikäihmisellä tulisi olla **omainen tai läheinen ihminen** (puoliso, lapsi, lastenlapsi, miniä, vävy, ystävä), joka käy häntä sairaalassa tapaamassa.

Olen pari kertaa viikossa yhteydessä osastoonne ja tiedustelen sopivia potilaita. **Tulen itse tapaamaan heitä ja kertomaan tutkimuksesta.** Jaan haastateltaville tiedotteen tutkimuksesta myös kirjallisena ja kehotan heitä keskustelemaan osallistumisesta läheistensä kanssa. Tulen muutaman päivän päästä uudelleen tapaamaan heitä, vastaamaan mahdollisiin lisäkysymyksiin ja sopimaan haastatteluajankohdasta. Haastatteluun osallistuvilta pyydän myös kirjallisen suostumuksen.

Potilaan ja omaisen niin halutessa haastattelisin heitä osastolla. Toivon, että osaston läheisyydestä löytyisi **sopiva rauhallinen paikka** nauhoitettavaa haastattelua varten. Haastatteluajankohdan voimme sopia niin, että se mahdollisimman vähän häiritsee hoitotoimenpiteitä tai kuntoutusta.

Ystävällisin terveisin

Jaana Koskenniemi, sh, TtM–opisk.
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Appendix 4. Example of information letter for interviews of older patients with memory disorders and next of kin in long–term care (related to Data II collection)

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10.12.2011

TIEDOTE MUISTISAIRAALLE JA HÄNEN LÄHEISELLEEN

Hyvä vastaanottaja

Olen Turun hoitotieteellisessä tiedekunnassa jatko–opintoja suorittava terveystieteiden maisteri. Teen väitöskirjatutkimusta arvostuksen toteutumisesta ikäihmisten hoitotyössä. Tutkimuksen tarkoituksena on kuvata, miten muistisairas ja hänen läheisensä kokevat arvostuksen toteutuvan koti– ja laitoshoidossa. Tutkimuksen tavoitteena on tuottaa tietoa ikäihmisen hoitotyön kehittämiseen.

Pyydän kohteliaimmin Teitä osallistumaan tähän haastattelututkimukseen. Haastattelutilanteessa olemme kahden kesken ja toivon suostumustanne haastattelun nauhoittamiseen. Haastattelu kestää noin tunnin.

Haastattelu on luottamuksellinen ja haastattelunauhoja käsittelen tutkijana vain itse. Tutkimuksen valmistuttua hävitän haastattelunauhat. Tutkimusraportti sisältää esimerkkejä haastatteluista, mutta henkilöllisyytenne ei tule esiin sillä esimerkeissä käytetään peitenimiä. Haastattelu perustuu vapaaehtoisuuteen ja Teillä on mahdollisuus keskeyttää osallistumisenne tutkimukseen milloin tahansa niin halutessanne.

Tutkimusaineisto kerätään syksyn 2011 ja kevään 2012 aikana. Tutkimuksesta kirjoitetaan artikkeli kansainväliseen alan tieteelliseen julkaisuun vuoden 2012 lopulla ja se raportoidaan Turun hoitotieteen laitoksella osana väitöskirjatutkimusta vuonna 2015. Tutkimuksen ohjaajina toimivat professori Helena Leino–Kilpi ja professori (ma) Riitta Suhonen Turun lääketieteellisen tiedekunnan hoitotieteen laitokselta.

Tutkimuksen suorittamiselle on saatu Varsinais–Suomen sairaanhoitopiirin eettisen toimikunnan puoltava lausunto sekä hoito–organisaatioiden luvat.

Halukkuutenne osallistua tutkimukseen voitte ilmaista esitteen Teille antaneelle hoitajalle tai ottamalla suoraan yhteyttä Jaana Koskenniemeen (040–7179645). Vastaan mielelläni lisäkysymyksiin. Juuri Teidän kokemuksenne ovat tutkimuksen kannalta arvokkaita.

Jaana Koskenniemi
Sairaanhoitaja, TtM
Turun yliopisto, hoitotieteen laitos
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Riitta Suhonen
Professori (ma)
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Appendix 5. Example of informed voluntary consent document for interviews of the older patients and next of kin (related to Data IV, V collection).

Jaana Koskenniemi
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20.4.2016

SUOSTUMUSASIAKIRJA

Pyydän suostumustanne kyselytutkimukseen, jonka tarkoituksena on kuvata iäkkään potilaan kokemuksia kunnioittavan kohtelun toteutumisesta hoidossa. Tavoitteena on tuottaa lisätietoa ikäihmisten hoitotyön käytäntöjen kehittämiseen.

Kyselytutkimus suoritetaan kevään–kesän 2016 aikana ja se raportoidaan Turun yliopiston hoitotieteen laitoksella väitöskirjana syksyllä 2017.

Tutkimukseen osallistuminen on vapaaehtoista. Aineisto kerätään nimettömänä ja se on ainoastaan tutkijan käytettävissä. Suostuessanne tutkimukseen, voitte missä vaiheessa tahansa keskeyttää osallistumisenne.

Avustanne kiittäen,

Jaana Koskenniemi
Sairaanhoitaja, Terveystieteiden tohtoriopiskelija
p. 040 – 7179645

Annan suostumukseni siihen, että antamiani tietoja käytetään mainitun tutkimuksen aineistona.

_____ ssa _____/_____ _____

_____

Nimi ja nimen selvennys

Suostumuksen vastaanottaja

_____

Nimi ja nimen selvennys

Appendix 6. Information letter and instruction for expert panel 1.

Turun yliopisto, lääketieteellinen tiedekunta, hoitotieteen laitos, jatkokoulutusseminaari 26.3.2015

Tutkimus: KUNNIOITTAVAN KOHTELUN TOTEUTUMINEN IKÄÄNTYNEIDEN POTILAIDEN KOKEMANA

ASIANTUNTIJAPANEELI 1

Arvoisa vastaaja,

Pyydän kohteliaimmin Sinua osallistumaan asiantuntijapaneliin arvioimalla väitöskirjatyössäni kehittämääni Respect Instrument © –mittaria.

Mittari on kehitetty mittaamaan potilaan kokemusta kunnioittavan kohtelun toteutumisesta potilaan ja hoitajan välisessä kohtaamisessa, ja siihen yhteydessä olevia tekijöitä. Mittarin taustana on kunnioittavan kohtelun hypoteettinen viitekehys, jossa kunnioittava kohtelu määritellään aitona välittämisenä, jossa hoitaja pyrkii yhteisymmärrykseen potilaan kanssa. Ikääntyneen potilaan kokemus kunnioittavasta kohtelusta potilas – hoitaja –suhteessa muodostuu hoitajasta ja hänen toiminnastaan ja niihin yhteydessä olevista tekijöistä, ja potilaaseen liittyvistä tekijöistä. Vastaajana on ikääntynyt potilas (≥ 65–vuotias, kykenevä kommunikoimaan ja antamaan tietoisen suostumuksen), joka arvioi väittämiä meneillään olevan hoitojakson (sairaala, terveyskeskuksen vuodeosasto) kokemustensa mukaan (> 2 vrk:n hoitojakso). Tutkija esittää kysymykset potilaalle ja potilas vastaa kysymyksiin oheisella VAS–asteikolla 0–100 TAI asteikolla täysin eri mieltä – täysin samaa mieltä (1= täysin eri mieltä, 2= eri mieltä, 3= jokseenkin eri mieltä, 4= jokseenkin samaa mieltä, 5= samaa mieltä, 6= täysin samaa mieltä).

Mittari koostuu kolmesta kategoriasta: I Hoitajan toimintaan liittyvät tekijät, II Hoitajan toimintaan yhteydessä olevat tekijät ja III Potilaaseen liittyvät tekijät. Hoitajan toimintaan liittyvät tekijät koostuvat viidestä luokasta (A–E), hoitajan toimintaan yhteydessä olevat tekijät kolmesta (F–H) ja potilaaseen liittyvät tekijät neljästä luokasta (I–L). Mittarissa on yhteensä 60 kysymystä. Lisäksi mittariin kuuluu 11 taustakysymystä.

Pyydän Sinua aluksi arvioimaan mittarin väittämien 12–71:
Selkeyttä: Onko väittämä yksiselitteinen ja selkeä? (1= ei selkeä, 4= selkeä)
Asiaankuuluvuutta: Onko tarpeellista kysyä? (1= asiaan kuulumaton, 4= asiaan kuuluva)
Tärkeyttä: Onko tärkeä tekijä ikääntyneen potilaan kunnioittavassa kohtelussa? (1= ei tärkeä, 4= tärkeä)

Lisäksi pyydän Sinua arvioimaan mittarin väittämien 12–71:
Saman asian mittaamista: Mittaako jokin muu väittämä samaa asiaa? (1= kyllä, mikä? 2= ei)
Väittämän paikkaa: Kuuluuko väittämä kyseiseen luokkaan? (1= ei kuulu, mihin? 2= kuuluu)

Lopuksi pyydän Sinua arvioimaan taustakysymysten 1–11:
Selkeyttä: Onko yksiselitteinen ja selkeä? (1= ei selkeä, 4= selkeä)
Asiaankuuluvuutta: Onko tarpeellista kysyä? (1= asiaan kuulumaton, 4= asiaan kuuluva)
Kattavuutta: Onko huomioitu keskeiset asiat? (1= ei kattava, 2= kattava)

Kommentteja voit halutessasi kirjata jokaisen osion perään.

Kiitos yhteistyöstä!

Jaana Koskenniemi

Appendix 7. Evaluation and modification of the ReSpect Scale in the expert panels.

Item	Expert panel 1 (n=10) Clarity (%)	Expert panel 1 (n=10) Relevance (%)	Expert panel 2 (n=5) Combinations of items	Final item in ReSpect Scale after modifications
I Hoitajan toimintaan liittyvät tekijät **A. Hyväksynnän osoittaminen**				**Hyväksyminen**
1. Hoitajat ovat olleet hyväksyviä (myötämielisiä ja hyväntahtoisia).	20	75		1. Hoitajat olivat hyväksyviä minua kohtaan.
2. Hoitajat ovat hyväksyneet minut tällaisena kuin olen.	100	90		2. Hoitaja hyväksyivät minut tällaisena kuin olen.
3. Hoitajat ovat kohdanneet minut ystävällisesti.	80	80		3. Hoitajat keskustelivat kanssani arvostavaan sävyyn.
4. Hoitajat ovat kohdelleet minua yhtä hyvin kuin toisia potilaita.	100	100		5. Hoitajat kohtelivat minua yhtä hyvin kuin toisia potilaita.
5. Hoitajat ovat ottaneet huomioon hoitoon liittyviä toiveitani.	90	100		
6. Hoitajat ovat ottaneet huomioon mielitekojani (ruokatoiveeni, ekstrakupin kahvia, seuraamani TV–sarjan).	80	77.8	Delete the item.	
7. Hoitajat ovat mahdollistaneet toimintani omien tapojeni ja tottumusteni mukaan.	90	100		4. Hoitajat mahdollistivat toimintani omien tapojeni mukaan.
8. Hoitajat ovat joustaneet hoitorutiineissa tarpeitteni mukaisesti.	55.6	87.5	Combined with the item 18.	
9. Hoitajat ovat kunnioittaneet elämänkatsomustani (esim. hengellinen, poliittinen, kulttuurinen).	77.8	100	Combined with the item 18.	
B. Kohtelias käyttäytyminen			Delete the whole domain	Delete the whole domain
10. Hoitajat ovat kohteliaita.	90	90	Delete the item.	
11. Hoitajat ovat toimineet niin, etten ole joutunut noloon tilanteeseen.	66.7	75	Delete the item.	
12. Hoitajat ovat käyttäytyneet hyvien tapojen mukaisesti.	90	80	Delete the item.	

Item	Expert panel 1 (n=10) Clarity (%)	Expert panel 1 (n=10) Relevance (%)	Expert panel 2 (n=5) Combinations of items	Final item in ReSpect Scale after modifications
13. Hoitajat ovat selittäneet minulle, mitä aikovat tehdä ennen kuin alkavat toimia.	90	77.8	Delete the item.	
14. Hoitajat ovat toimineet hienotunteisesti intiimitilanteissa (esim. WC– ja pesutilanteet).	100	75	Delete the item.	
15. Hoitajat ovat puhuneet asioistani keskenään huomioiden samalla minut.	44.5	100	Delete the item.	
16. Hoitajat ovat tehneet hoitoani koskevia päätöksiä keskustellen niistä kanssani.	70	90	Delete the item.	
17. Hoitajat ovat hoitaneet minua kiireettömästi.	70	66.6	Delete the item.	
18. Hoitajat ovat keskittyneet minuun hoitotilanteissani.	100	100	Delete the item.	
C. Aktiivinen vuorovaikuttaminen				**Kuunteleminen**
19. Hoitajat ovat olleet vastaanottavaisia (avoimia ja keskustelevia).	50	80		6. Hoitajat olivat kuuntelevia.
20. Hoitajat ovat luoneet toiminnallaan luottamuksellisen hoitoilmapiirin.	66.6	77.8		20. Hoitajat loivat turvallisen hoitoilmapiirin.
21. Hoitajat ovat tiedustelleet vointiani oma–aloitteisesti.	80	70	Combined with the item 7.	
22. Hoitajat ovat järjestäneet aikaa keskustella kanssani.	70	80		8. Hoitajat antoivat minun ilmaista sanottavani rauhassa.
23. Hoitajat ovat kuunnelleet minua tarkkaavaisesti.	100	90		7. Hoitajat olivat kiinnostuneita minun mielipiteistäni.
24. Hoitajat ovat ottaneet tosissaan sen, mitä sanon heille.	88.9	100		9. Hoitajat ottivat sanottavani tosissaan.
25. Hoitajat ovat reagoineet sanomisiini aina jollakin tavalla.	70	80	Combined with the item 35.	
26. Hoitajat ovat olleet herkkiä aistimaan, jos jokin painaa mieltäni.	80	70		10. Hoitajat ymmärsivät minua.

Item	Expert panel 1 (n=10) Clarity (%)	Expert panel 1 (n=10) Relevance (%)	Expert panel 2 (n=5) Combinations of items	Final item in ReSpect Scale after modifications
27. Hoitajat ovat vastanneet avuntarpeeseeni ennen kuin olen ehtinyt pyytää.	100	70	Combined with the item 37.	
D. Huolenpito				**Huolenpito**
28. Hoitajat ovat olleet huolehtivaisia (vastuullisia ja auttavaisia).	60	77.8		16. Hoitajat ovat olleet huolehtivaisia minua kohtaan.
29. Hoitajat ovat toiminnallaan vahvistaneet turvallisuuden tunnettani.	90	90	Combined with the item 31.	
30. Hoitajat ovat aktiivisesti seuranneet vointiani.	70	60	Combined with the item 54.	
31. Hoitajat ovat tulleet nopeasti kutsuttaessa (esim. soitan kelloa).	90	80	Combined with the item 47.	
32. Hoitajat ovat huolehtineet hyvästä perushoidostani.	60	90	Combined with the item 39.	
33. Hoitajat ovat selvittäneet minulle hoitooni liittyviä asioita ymmärrettävästi.	90	90	Delete the item.	
34. Hoitajat ovat pitäneet minut ajan tasalla hoitooni liittyvissä asioissa kysymättä.	70	70	Delete the item.	
35. Hoitajat ovat varmistaneet onko minulla kysyttävää ennen kohtaamisen päättymistä.	70	80	Delete the item.	
36. Hoitajat ovat varmistaneet, että saan tarvitessani yhteyden hoitajaan.	60	70		17. Hoitajat olivat tavoitettavissa, kun tarvitsin heitä.
E. Rohkaiseminen				
37. Hoitajat ovat olleet rohkaisevia (positiivisia ja kannustavia).	80	90		11. Hoitajat olivat kannustavia minua kohtaan.
38. Hoitajat ovat tukeneet minua terveyteeni liittyvissä elämänmuutoksissa.	70	90		19. Hoitajat näkivät vaivaa hyvinvointini eteen.
39. Hoitajat ovat lohduttaneet minua, kun olen ollut sen tarpeessa.	100	90		15. Hoitajat pitivät yllä toivoa.
40. Hoitajat ovat rohkaisseet minua ilmaisemaan toiveitani / tarpeitani.	90	90	Combined with the item 52.	

Item	Expert panel 1 (n=10) Clarity (%)	Expert panel 1 (n=10) Relevance (%)	Expert panel 2 (n=5) Combinations of items	Final item in ReSpect Scale after modifications
41. Hoitajat ovat kannustaneet minua osallistumaan hoitoani koskevaan keskusteluun.	100	100		14. Hoitajat rohkaisivat minua osallistumaan hoitooni.
42. Hoitajat ovat vahvistaneet uskoani itsenäiseen selviytymiseeni.	80	80		13. Hoitajat vahvistivat uskoa omiin kykyihini.
43. Hoitajat ovat tukeneet minua omatoimisuuden saavuttamisessa.	60	90		18. Hoitajat auttoivat minua monin tavoin.
44. Hoitajat ovat rohkaisseet minua käyttämään omia voimavarojani.	60	100	Combined with the item 52.	
45. Hoitajat ovat antaneet minulle tunnustusta itseni hoitamisessa.	70	88.9		12. Hoitajat antoivat tunnustusta minulle.
II Hoitajan toimintaan yhteydessä olevat tekijät **F. Hoitotyön edellytysten varmistaminen**				
46. Osastolla on ollut hyvä ilmapiiri.	80	80		
47. Hoitajia on ollut riittävä määrä hoitamassa potilaita.	70	80	Delete the item.	
48. Hoitajien vaihtuvuus osastolla on ollut vähäistä.	60	70	Delete the item.	
49. Hoitajat ovat olleet motivoituneita hoitamaan potilaita.	90	90		21. Hoitajat olivat motivoituneita hoitamaan minua.
50. Hoitajat ovat olleet tehtäväänsä päteviä.	70	80		22. Hoitajat olivat päteviä hoitamaan minua.
51. Hoitajat ovat olleet tehtäväänsä sopivia.	70	80		23. Hoitajat olivat sopivia hoitotyöhön.

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