**Being respected by nurses: measuring older patients' perceptions**


## Abstract

**Aim and objective:** To investigate older patients' perceptions of the respect shown by nurses in hospital care and to test a new developed instrument measuring the phenomenon.

**Background:** Respect manifests itself in the older patient-nurse relationship in terms of nurses being with and doing for the patient. Empirical studies investigating respect from the older patients' perspective are rare. There is a need to maintain respectful behaviours and attitudes within hospital- based nursing practice. Further, there is a lack of instruments measuring respect shown in the care provided by nurses.

**Design and methods:** A descriptive, cross-sectional explorative survey design was used. Data were collected between February and May 2016 by interviewing face-to-face 196 older patients in two hospitals in Finland. Respect was measured using the ReSpect scale (Parts A and B) developed for this study. Respect is based on the two dimensions of respect, nurses' *Being with* and *Doing for* patients. Data were analysed using descriptive and inferential statistical methods including the psychometric testing of the new instrument.

**Results:** Older patients perceived respect in their care frequently and to a great extent, though there were also shortcomings. The findings highlight the need to improve respect to patients in care delivery by showing an interest in their views, acknowledging them positively and supporting their individual capacities. A two-factor structure of the Respect scale Part A and a four-factor structure of the Part B was confirmed.

**Conclusions:** Findings from this study suggest that nurses do show respect to their hospital patients overall, but the area where there is the most room for improvement is that of listening and encouraging. The psychometric analysis demonstrated that the ReSpect scale shows promise in measuring respect.

**Implications for practice:** The ReSpect scale could be a useful tool to measure respect, an important element of value-based healthcare.



KEYWORDS**:** respect, ethics, older patients, nursing care, instrument, psychometric testing

## SUMMARY STATEMENT OF IMPLICATIONS FOR PRACTICE

2-3 bullet points, 20-30 words, should stand alone, discussed in discussion section

**What does this research add to existing knowledge in gerontology?**

- Older patients' perceptions of being respected by nurses is essential to be known when maintaining value-based health care.
- This study produced an instrument measuring respect shown to older patients, which is important when enhancing ethical quality in nursing care.

**What are the implications of this new knowledge for nursing care with older people?**

- Nurses could improve perceptions of respect by acknowledging older patients and their views positively whilst taking an interest in and supporting their individual capacities.
- The ReSpect scale could be a useful tool to measure respect, an important element of value-based healthcare.

**How could the findings be used to influence policy or practice or research or education?**

- The findings of this study could be used in maintaining value-based health care and enhancing ethical quality in nursing care.
- This study introduces the ReSpect scale by allowing respect to be examined empirically with operational definitions.

# 1 INTRODUCTION

To be cared for with respect is considered a fundamental right of patients in health care (Downie et al. 1994, WHO 2002, European Commission 2007) and showing respect is a professional obligation in the delivery of ethically high-quality care (Dillon 1992, ICN 2012). Respect is the most constitutive professional value in nursing care (Brownie 1993, Downie et al. 1994, Fry & Johnstone 2008) aiming to: maintain human dignity (Coverty 2006, Di Bartolo 2006, Kalb & O'Conner-Von 2007, Ferri et al. 2015); preserve integrity (Teeri et al. 2006, 2008); protect privacy (Birrel et al. 2006) and enhance autonomy (Välimäki et al. 2001, Scherwin & Winsby 2010, Welford et al. 2010) and self-determination (Hellström & Sarvimäki 2007) in the patient-nurse relationship. Although the need for respect in health care is widely recognized (Gallagher 2004, Gallagher et al. 2008), respect has seldom been a topic of nursing studies. Especially empirical studies investigating older patients' perceptions of being respected by nurses are rare. This study aims to reduce this gap.

## 1.1 Background

Respect shown in the patient-nurse relationship during care requires a caring attitude which adopts and adapts the knowledge of ethical principles and caring theories to facilitate appreciative behaviours and attitudes in all caring encounters in nursing practice (Browne 1993, Gallagher 2004, Gallagher et al. 2008, Koskenniemi et al. 2015). Previous research investigating respect in older patients' care in clinical practice has been linked to patient-centred (Dewin 2004, Abley 2012, Broderick & Coffey 2013) or person-centred (Nolan et al. 2004, McCormack & McCance 2006) care and reciprocal caring relationships (Bayer et al. 2005, Berg et al. 2007). Showing respect in patient-nurse relationships is concerned with caring attitudes (Peplau 1997, Buzgova & Ivanova 2011, Chung 2013, Moe et al. 2013) and shared decision-making focused on patients' wishes and expectations (Holmberg et al. 2012,

Jonasson & Berterö 2012, Körner et al. 2013, Aboumatar et al. 2015). Respect is also shown in caring behaviours and through verbal and non-verbal communications which demonstrate humility and sensitivity (Hansebo & Kihlgren 2002, Nåden & Eriksson 2004, Kvåle & Bondevik 2008) and a mutual positive regard (Berg et al. 2007, Medvene & Lann-Wolcott 2010). These elements of value-based care work together synergistically as part of the strategy to achieve a deeper understanding of the patients' perspective (Jonasson et al. 2010, Thompson et al. 2011).

Earlier studies have identified obstacles to respect in the care of older patients. These obstacles include nurses' negative attitudes (Moe et al. 2013), poor ethical competence (DeHart et al. 2009) and caring behaviours (Buzgova & Ivanova 2011), and failing to allow patients to participate in decision-making processes (Körner et al. 2013). These obstacles must be overcome as respect is a fundamental human right, is valued in health care and nursing ethics (Fry & Johnstone 2008) and should be perceived by patients (Browne 1993, Gallagher 2004, 2008). To overcome obstacles and develop this valued human right in health care, it is essential that respect is investigated and measured. It is pertinent that investigations consider older patients' perceptions of nurses' behaviours and attitudes towards respect in caring situations (Koskenniemi et al. 2013, 2015).

Defining the abstract concept of respect in nursing care is challenging (Browne 1993, Gallagher 2008). This challenge could be one reason why respect has only been measured as part of other nursing concepts, such as the quality of care (Can et al. 2008, Adra et al. 2015); care satisfaction (Bowersox et al. 2013, Ferri et al. 2015); good nursing care (Leino-Kilpi 1992); as a precondition of individualized care (Suhonen et al. 2000) and measuring caring behaviours (Wolf et al. 2003). For example, the Caring Behaviours Inventory CBI-24, developed by Wolf et al. (2003), based on Jean Watson's Transpersonal Caring Theory

(Watson 1985), has one dimension (out of four) which measures respectful deference to others. However, respect for patients is important enough to be studied as a single element of care (Duffy et al. 2007, Aboumatar et al. 2015).

## 1.2 The present study

The manifestation of respect in nurses' being with and doing for patients provides the theoretical basis for the meaning of respect in this study (Mayeroff 1971, Koskenniemi et al. 2015). The manifestation of respect in nurses being with patients is related to nurses' essence and the way they commit to caring for older patients. Respect is perceived by older patients when nurses are felt to be approving (Hansebo & Kihlgren 2002, Berg et al. 2007, Holmberg et al. 2012, Jonasson & Berterö 2012), active listeners (Jonasson et al. 2010, Thompson et al. 2011), supportive (Hansebo & Kihlgren 2002, Hellström & Sarvimäki 2007) and attentive (Whitbread 2008). Furthermore, respect is perceived by older patients when nurses are seen to be committed (Jonasson et al. 2010); motivated, by showing interest in older patients as human being and conveying willingness to care them (Thompson et al. 2011); proficient, by having good communication skills and inspiring confidence (Dickert & Kass 2009, Thompson et al. 2011); and adaptable, by being solicitous and thoughtful and showing kind attitudes for caring for older patients (Nåden & Eriksson 2004, Percival & Johnson 2013).

The manifestation of respect in nurses' doing for patients is defined in terms of nurses' actions showing: acceptance, listening, encouraging and nurturing (Koskenniemi et al. 2015). Kind words and compassionate care delivery, based on mutual understanding, have been found to increase patients' feelings of being accepted (Hallström & Elander 2001, Thompson et al. 2011, Van der Elst 2011, Koskenniemi et al. 2015) and valued as unique persons (Dickert & Kass 2009, Holmberg et al. 2012). Listening to older patients and taking their points of views seriously are also crucial in the perception of respect (Nåden & Eriksson

2004, Jonasson et al. 2010, Thompson et al. 2011, Koskenniemi et al. 2015). Additionally, taking care of patients' basic care needs, giving support through assistance and encouraging participation in care in line with older patients' individual physical and mental capacities (Jonasson & Berterö 2012, Koskenniemi et al. 2015) are integral in perceived respect. Respect develops trust and a safe, caring atmosphere, which is essential for perception of respect for older patients (Berg et al. 2007, Jonasson et al. 2010, Medvene & Lann-Wolcott 2010, Koskenniemi et al. 2015). Based on this theoretical foundation, the ReSpect scale was developed to measure the extent to which older patients perceive being respected by nurses during their nursing care in hospital.

The aim of this study was to investigate older patients' perceptions of the respect shown by nurses in hospital care and to test a new developed instrument measuring the phenomenon. The following research questions were set:

- To what extent do older patients perceive being respected in hospital nursing care by nurses?
- What are the psychometric properties of the ReSpect scale?

# 2 METHOD

## 2.1 Participants and sampling

A sample of 200 older patients from eleven rehabilitation wards in two hospitals in an urban area in South-West Finland was recruited from patients who were in need of medical or surgical treatment or rehabilitation after surgery. The hospitals were selected because they admitted the highest number of older patients in need of follow-up treatment in the caring area in question. The participants were 1) older people (aged 65 or over); 2) hospitalized for

at least five days (including arrival and discharge days); 3) able to communicate in Finnish; 4) oriented in time and place, as assessed by nurses, and 5) willing to participate voluntarily in the study. Patients were excluded if they had severe cognitive deficits, as assessed by their nurses.

The sample size required was based on number of the items (23) in the ReSpect scale. The methodological literature suggests that a sufficient sample should be 5 to 10 times the number of items (Grove et al. 2013), around 200 participants. A total of 215 older patients, all of whom gave oral consent to participate, were approached by the interviewers, but 15 of them withdrew before interview.

The data were collected between February and May 2016 by interviewing older patients (n=200) individually during their discharge process. The age of the participants ranged from 65 to 100 years (M=82.1, SD=8.1) and most of them were in the age group 76-85 years (40.3%, n=79). Two thirds ~~of them~~ were female (67%, n=131) and lived alone (64%, n=125). All participants were white people, most ~~of them~~ had no vocational education (63%, n=123) and a minority had university education (7%, n=13). The reasons for hospitalization were assessed by the patients themselves. Most patients were suffering from different medical symptoms (47.9%, n=94), like dizziness, general weakness or pain, and one-fifth were in need of rehabilitation after surgery (18.4%, n=36) or caring for infection (18.4%, n=36). The mean length of the participants' current hospital stay was 14 days (range 5-120, SD=14.1).

Two interviewers (JK/RH) collected the data using the data collection procedure that had been planned and agreed beforehand. After the provision of informed consent, the participants were instructed to evaluate all nurses (registered and assistant nurses) who cared for them in the ward during their current hospital stay. Nurses were differentiated from cleaning staff with white costumes. Participants were asked to think of an average value that

described their evaluation of the respect they received from the nurses in each of the elements of the ReSpect scale. The interviewers repeated the answers given by the participants and documented their evaluations on the scale as the participants watched.

## 2.2 Ethical considerations

The study followed the principles of Biomedical ethics, (Beauchamp & Childress 2013, The European Code of Conduct for Research Integrity 2017), was approved by the Ethics Committee of the University (Statement 44/2015) and permission to collect the data was obtained from the relevant hospital authorities. Potential interviewees were informed of the purpose of the study orally and in writing and asked to contact nurses in each participating ward if they were willing to participate in the study. After the patients had contacted these nurses and given oral consent to participate in the study, the patients' details were passed to the researchers who contacted them. The patients received a covering letter containing more substantial information about the study, the principles of voluntary participation, anonymity and the confidentiality of the data. The potential participants were then given the opportunity to ask questions concerning the study protocol. Written informed consent was obtained immediately before the structured interview.

## 2.3 Measurements

***The ReSpect scale*** was developed for the measurement of older patients' perceptions of respect in the care provided by nurses. It was developed inductively based on interviews with older patients and their next of kin about respect in older patients' nursing care in different care settings (Koskenniemi et al. 2013, 2015), and utilizing respect literature (Table 1.). The resultant item pool (n=48) was created directly from the interview transcriptions to reduce interpretation and was critically discussed in two panels consisting of experts in nursing

research. In the first panel (n=10), the content validity of the ReSpect scale was assessed to enhance the relevance (1=not relevant- 4=very relevant) and clarity (1=not clear- 4=very clear) of the items (using 80% agreement on clarity) (Waltz et al. 2005). During the discussion, similar items were combined, leading to a reduction from 48 to 33 items. The second panel of nurse researchers in ethics (n=5) was then convened to further analyse the relevance and clarity of these 33 ReSpect scale items, after some re-combinations and re-specifications, the number was reduced further to 23 items. The ReSpect scale was then pilot-tested in a sample of 30 older patients in one hospital to assess the clarity of the items, the instructions to participants and to standardize the measurement technique. Some redundant words were deleted and a few changes in word orders made after the pilot test.

The ReSpect scale is divided into two parts: part A, Nurses' *Being with* patients and part B, Nurses' *Doing for* patients. Nurses' *Being with* has two sub-scales, the first measuring respect in nurses' *essence* (four items), and the second measuring respect in nurses' *commitment* (three items). Nurses' *Doing for* has four sub-scales of four items each, measuring respect in nurses' actions concerned with *accepting*, *listening*, *encouraging*, and *nurturing*. The whole ReSpect scale consists of six sub-scales (23 items, Table 2.) and uses a Visual Analogue Scale (VAS) with a response range from 0 (never) to 100 (always) (Figure 1.). The higher the scores, the more respect is perceived.

One sub-scale of the Caring Behaviours Inventory (CBI-24; Wolf et al. 2003) was also used. The CBI-24 is a valid and reliable tool for measuring the caring behaviours practiced by nurses (Wu et al. 2006, Papastravou et al. 2012). Permission for the use of the ***CBI-Respectful Deference to Others (CBI-RDO)*** sub-scale as a criterion instrument for the ReSpect scale was obtained on 14 Jan 2016 (Wolf, personal contact). The CBI-RDO sub-scale has six items, each using a 6-point Likert-type scale with response options ranging from 1 (never) to 6 (always) (Table 2). The higher the score, the more caring is perceived.

## 2.4 Data analysis

The statistical software package SAS 9.3 (SAS Institute Inc., Cary, North Carolina, USA) was used to analyse the data. Descriptive statistics were used to provide the means, standard deviations, and ranges from the demographic data, and each item in the ReSpect scale and its sum-variables. The sum-variables, six individual sub-scales and one whole scale, were calculated by adding together the item scores in each of the sub-scales and dividing this sum by the number of items in the sub-scale. There were no missing values in these items. The mean score for the total scale was calculated by adding the scores for each item and dividing this sum by 23.

The psychometric properties of the ReSpect scale were analysed at item and total scale levels. Cronbach's alpha coefficient was calculated as a measure of internal consistency for the ReSpect scale, its parts (A and B) and the six individual sub-scales and the CBI-RDO sub-scale. Item-total and inter-item correlations were also computed. Bartlett's test was used to assess sampling adequacy and the Kaiser-Meyer-Olkin test to quantify the suitability of the data for factor analysis. A Principal Component Analysis (PCA) and Promax rotation (factor analysis) was used to evaluate the construct validity of the parts A and B of the scale. Pearson's correlation between the ReSpect scale and the CBI-RDO sub-scale was used to assess criterion validity (Grove et al. 2013).

# 3 RESULTS

## 3.1 Being respected by nurses

The mean score (±SD) for the ReSpect scale was 76.4 (SD=17.8, max=100), suggesting that overall, participants perceived respect in their care frequently (Table 2.). Quite similar results

were found for Part A, *Being with* (M=77.5, SD=17.7) and Part B *Doing for* (M=75.9, SD=18.0). However, within this overall result some shortcomings were found.

In part A *Being with*, the first sub-scale portraying the essence of the nurse, participants perceived nurses to be attentive frequently (M=77.6, SD=20.5) and to be supportive a little less frequently (M=74.1, SD=22.1). The range of answers varied from never (0) to always (100) for the item being supportive. In the other sub-scale in Part A, representing the commitment of the nurse, participants perceived nurses to be proficient to care (M=80.8, SD=19.2) frequently and being motivated to care (M=77.1, SD=21.2) a little less frequently.

Overall, the range of scores for the four *Doing for* sub-scales (Part B) was higher than those for the *Being with* sub-scales (Part A). The participants felt accepted (M=78.4, SD=17.3) and nurtured (M=77.6, SD=19.6) more frequently than listened to (M=74.4, SD=19.4) and encouraged (M=73.3, SD=20.8). Over the total scale, nurses were perceived to show respect most frequently in the way nurses "treated all patients equally" (M=82.8, SD=17.7) and less frequently when they "showed interest in their patients' views" (M=68.4, SD=22.7). Within the encouraging sub-scale (M=73.3, SD=20.8), three items varied from never (0) to always (100), indicating that there was considerable variation in patients' perceptions of nurses' ways of conveying support to patients' individual capacities, encouraging patients to take part in their own care, and working to maintain patients' hope.

## 3.2 Psychometric properties of the ReSpect scale

From the 200 participants, four completed interviews were omitted from analysis due to missing values, leaving 196 participants. Cronbach's α value for the total ReSpect scale was 0.98, for its parts 0.93 (A) and 0.97 (B), and for the sub-scales the values ranged from 0.91 to 0.93. (Table 2.). Cronbach's α values higher than 0.70 indicate strong inter-correlation of the

items, suggesting that the items work well together and that the internal consistency reliability for the total scale and its parts are acceptable (Grove et al. 2013). Furthermore, item-total (ranging from 0.78 to 0.91) and inter-item (ranging from 0.68 to 0.86) correlations also provide support for internal consistency.

The Cronbach's alpha coefficient for the CBI-Respectful Deference to Others sub-scale was 0.91 and Pearson's correlation coefficient between the ReSpect scale and the CBI-RDO sub-scale was 0.83, supporting the criterion validity of the ReSpect scale.

Bartlett's test indicated that the samplewas adequate (<0.0001), and the Kaiser-Meyer-Olkin test (0.956) values ranging from 0.90 to 1.0 (excellent) indicated that the sampling was suitable for factor analysis (Streiner & Norman 2008). The construct validity of the ReSpect scale was analysed using Principal Component Analysis (PCA) with Promax rotation (Table 3.). The PCA 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.

## 4 DISCUSSION

The aim of this study was to investigate older patients' perceptions of the respect shown by nurses in hospital care and to test a new developed instrument measuring the phenomenon. The results showed that overall, the older patients in this study felt well respected by their nurses. However, the whole response range of the VAS scale (Figure 1), from 0 (never) to 100 (always), used by some participants, indicated that around 25% felt less frequently respected. The area the most room for improvement is that of listening and encouraging (Table 2). The results also showed that the ReSpect scale could be a useful tool to measure this important element of value-based healthcare.

## 4.1 Respect shown in the care provided by nurses

Older patients' perceptions of being respected by nurses is essential to be known when maintaining value-based health care and enhancing ethical quality in nursing care. In previous studies, respect has been measured as a component of other important concepts in nursing care (for example, Leino-Kilpi 1992, Suhonen et al. 2000, Wolf et al. 2003, Duffy et al. 2007, Can et al. 2008, Bowersox et al. 2013). In this study, the meaning of respect is defined in a structured way with older patients' own words (Koskenniemi et al. 2015) and tested with the ReSpect scale developed based on that meaning.

In the literature, respect has been emphasized as nurses' active engagement with patients requiring acknowledgement and preservation of the worth of the patient (Gallagher 2004, Gallagher et al. 2008). The older patients gave the highest ratings of respect for nurses' commitment to care for them in terms of being motivated, proficient and adaptable. This was contrary to earlier studies, which have identified negative caring attitudes (Moe et al. 2013), poor ethical competence (DeHart et al. 2009) and unethical caring behaviours (Buzgova & Ivanova 2011).

High ratings were also given for feeling respected in terms of being accepted. The acceptance of another person has previously been shown to demonstrate respect and it is a foundation of ethical nursing care (Browne 1993). This foundation is important for the protection of human dignity (Coverty 2006, Di Bartolo 2006, Kalb & O'Conner-Von 2007) and for enhancing patients' integrity (Teeri 2006, 2008). One reason for the high ratings of the perception of personal acceptance could be that the older patients in this study were discharged from hospital and felt quite independent. Earlier studies suggest that patients who are particularly dependent on nurses' assistance have impaired cognition or communication difficulties or feel a lack of personal acceptance (Moe et al. 2013, Oosterveld-Vlug et al. 2014) which in

some circumstances has led to the danger of neglect or even mistreatment (Buzgova & Ivanova 2009).

In this study, high ratings were also given for the nurturing aspect of respect as nurses created a safe, caring atmosphere and helped patients in many, sometimes indefinable ways. This high rating indicates that nurses were available when needed and worked to improve patients' wellbeing. According to earlier studies nurses were seldom seen to be spending time with their patients (Koskenniemi et al. 2015), were not always willing to help their patients (Moe et al. 2013) or were not attentive to their individual needs (Körner et al.2013). Earlier literature also indicates that patients have felt uncomfortable, anxious or even afraid during care delivery (DeHart 2009, Buzgova & Ivanova 2011).

The lowest ratings of respect were about showing interest in patients' views within the listening sub-scale. These ratings support the findings of earlier studies suggesting that nurses should interact with their patients more often and listen carefully to their points of views (Koskenniemi et al. 2013, 2015). The need for preparing for and engaging in empathic and meaningful relationships with patients is also widely expressed in earlier respect literature (Heliker & Nguyen 2010, Jonasson et al. 2010, Thompson et al. 2011, Jonasson & Berterö 2012, Papastavrou et al. 2012, Koskenniemi et al. 2013, 2015). Person-centred care which fundamentally requires nurses to listen to their patients, is broadly accepted as an appropriate basis for care delivery (Dewin 2004, McCormack & McCance 2006). However, this study reports some poorer attitudes towards and an ignorance of the skills required to facilitate patients' personal expressions of their situation and to notice patients' views and take them seriously. This finding concurs with earlier literature (Leino-Kilpi et al. 2003, Koskenniemi et al. 2013, 2015).

The results of this study indicate that more attention should be paid to encouraging older patients. Almost one in three participants would have liked more acknowledgement, support for maintaining their individual capacities, encouragement to participate in decision-making concerning their own care and more help with the maintenance of hope. Patients' desire for more participation in decision-making processes is supported by many earlier studies with older people (for example Kvåle & Bondevik 2008, Jonasson & Berterö 2012, Körner et al. 2013, Periyakoil et al. 2013). Furthermore, Eldh et al. (2006) reported that it is essential to respect patients' description of their situation rather than invite them to participate in decision-making based on nurses' descriptions. By concentrating on their patients' descriptions, nurses could better learn how to come to know their patients, through hearing about their individual expectations and hopes and by working to strengthen their patients' individual capacity to become involved in their own care.

Although the participants in this study felt that overall, nurses frequently showed respect in nursing care delivery, it is important to keep the shortcomings in mind. Nurses may improve the respect they convey to older patients by showing more interest in patients' views, acknowledging them positively and supporting them in accordance with their individual capacities. To make a necessary change in care delivery, nurses need to use the theoretical basis of respect in their nursing practice and develop the behaviours and attitudes required to respect older patients in hospital care.

## 4.2 Measuring respect

Based on the psychometric analysis of the ReSpect scale, the scale shows promise in the measurement of respect. Using the total score, organizations can examine the ethical quality of nursing care in terms of the respect shown and using the sub-scale analysis, identify

specific areas where the respect shown is good or needs improvement. Furthermore, the factor analysis of Parts A and B of the ReSpect scale (Table 3) supported the theoretical construction in this study (Koskenniemi et al. 2015). However, there were some overlaps between factors (see items 8, 10, 12 and 22 in Table 3.). It can be asked, if the sub-scales are too similar and, if they measure the same subject. Therefore, the ReSpect scale needs more testing to detect whether the sub-concepts can be combined and the scale shortened.

It is important to note that the ratings recorded for Part A, *Being with*, were slightly higher than ratings for Part B, *Doing for,* indicating that nurses may pay respect to their patients more in thought (the essence) than in deed (actions) (Table 2). The ratings for the total ReSpect scale were similar to those for Part B, suggesting the need of future research in the relationship between *Being with* and *Doing for*.

## 4.3 Limitations and future research

Although useful, the results of this study should be treated with some caution as the study was conducted in the rehabilitation wards of only two Finnish hospitals making generalizations difficult. The research topic was concerned with people’s perceptions and some participants may have found it difficult to describe the abstract concept in empirical terms using the VAS. However, the research question and approach is justified because of the limited empirical evidence about this topic and the obstacles identified in earlier studies (Moe et al. 2014, Buzgova & Ivanova 2011, DeHart et al. 2009).

The research data were attained over four months using a data collection protocol devised rigorously by the principal investigator (JK). The participants were well informed about the study, the interviewers had no influence on the selection of participants, and the principles of

voluntariness and confidentiality were followed. Both interviewers (JK/RH) had previous experience of interviewing older patients, and they familiarized themselves with the questionnaire together to maximize the standardization of the data collection procedure.

The strength of the data collection method was that older patients were interviewed individually (Peel & Wilson 2008). By presenting the questions orally as a structured interview, any visual and motoric difficulties, which might have occurred in a self-report data collection system, were reduced. Furthermore, it was possible to continue the interviews until the calculated sample size, required for a valid and reliable study, had been reached. The sample size was found to be adequate for the analysis of a new instrument (Bartlett's test, Table 2). However, the answers to the questions were not written by the participants, but given orally and written down by the interviewer and the participants may have answered with a positive bias. To reduce this bias, the interviewers repeated the answers after the participants' responses and marked the response option chosen as the participants watched. These techniques increased the rigour of the data collection procedure.

The participants were asked to respond to the structured interview questions in the context of the care delivered in the hospital ward from which they had been discharged. Some patients reflected on earlier hospitalizations during the interview and it is possible that they responded with these memories in mind. Furthermore, some older patients felt uncomfortable about answering some of the questions, not wanting to criticize their nurses (Hall et al. 2009, Koskenniemi et al. 2015). Other participants strived to make excuses for nurses and their behaviour, which may have biased the results positively.

A version of the VAS (Figure 1) was used in this study facilitating ease of use. The scale was presented as a line from 0 to 100 marked out in groups of ten, rather than simply labelling the end-points (Streiner & Norman 2008). The VAS scale was illustrated with pictures and

colours and discussed before the start of the interview, making the scale appropriate for any participants who had less abstract ability or a cognitive disorder (Williamsson & Hoggart 2005).

The psychometric properties of the ReSpect scale were good and the criterion validity was supported (Grove et al. 2013). High Cronbach's alpha coefficient may indicate the redundancy of the items (Tavakol & Dennick 2011, Taber 2017). However, by deleting items the breath and width of the concept will be reduced losing older patients' descriptions of the concept. Future testing of the ReSpect scale to demonstrate its reliability, should concentrate initially on older people in different care settings. Further development of the scale would make it possible to measure the respect shown from the perspectives of patients' relatives and nurses. Moreover, further development could include analyses of the sensitivity and separation of the items which, if improved, may shed more light on the differences between nurses *Being with* and *Doing for* patients.

## 4.4 Concluding thoughts

This study highlights older patients' perceptions of the respect shown to them by nurses in a way that has not been reported previously. The findings from this study suggest that nurses could improve perceptions of respect by acknowledging older patients and their views positively whilst taking an interest in and supporting their individual capacities. This study introduces the ReSpect scale by allowing respect to be examined empirically with operational definitions. The ReSpect scale could be a useful tool to measure respect, an important element of value-based healthcare.

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