Title: Respect and its associated factors as perceived by older patients

Running title: Respect in older patients' nursing care

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Respect and its associated factors as perceived by older patients

Aims and objectives: To investigate older hospital patients' perceptions of respect in a patient-nurse relationship and its associated factors.

Background: To be cared for with respect is fundamental to ethical nursing care. However, respect has seldom been a main topic of nursing research, and few of these studies have assessed older patients' perceptions of being respected by nurses alongside associated factors.

Design: A cross-sectional, descriptive and correlational survey design.

Methods: Hospitalized older patients (n=200) were interviewed using the ReSpect scale measuring respect within the nurse-patient-relationship, the EuroQol 5D-5L, measuring perceived health status and the Patient Satisfaction Scale, measuring satisfaction with nursing care. Sociodemographic characteristics were also collected. Data were analyzed using descriptive statistics, Pearson's correlation coefficient, the t-test and analysis of variance. The STROBE Statement was used for reporting this research.

Results: Older patients reported moderate levels of perceived respect in their patient-nurse-relationships. A statistically significant, strong positive correlation between patient satisfaction and their perceptions of respect was found. Poor perceived health status was also statistically significantly associated with older patients' perceptions of respect. No statistically significant associations between patients' other sociodemographic characteristics and their perceptions of respect, were found.

Conclusions: The identification of factors and their associations with respect is a basic step towards theory generation. Further empirical research is needed to test the preliminary associations found in this study to further develop the current understanding of respect and its associated factors.

Relevance to clinical practice: The older patients' perceptions of respect highlighted in this study show the need for the further consideration, reflection and development of this important aspect of the relationship between patients and nurses. The identification and measurement of respect and its associated factors may help to improve respect in nursing care making it more visible in the care of older people.

Keywords: respect, ethics, older patient, nursing care, health status, quality of care, psychometric testing

Summary box

What does this paper contribute to the wider global clinical community?

- The study sheds light on older patients' perceptions of respect and associated factors, raising its profile and facilitating its identification and measurement, which may lead to improved respectful encounters in the workplace.
- Increased respect conveyed by nurses may improve patients' perceived health status and increase their satisfaction with nursing care.
- Value-based health care could be enhanced by further investigation of the factors associated with respect as perceived by patients.

Introduction

Respect is a fundamental professional value in nursing practice (Browne, 1993; Fry & Johnstone, 2008) and similarly an essential right of patients in health care (Fry & Johnstone, 2008; WHO, 2015). Respect has an ethical quality: maintaining human dignity (Coventry, 2006; DiBartolo, 2006); preserving integrity (Teeri, Leino-Kilpi & Välimäki, 2006); protecting privacy (Birrel, Thomas & Jones, 2006); and enhancing autonomy (Welford, Murphy, Wallace & Casey, 2010) and self-determination (Hellström & Sarvimäki, 2007) in all relationships between patients and professionals (Browne, 1993; ANA, 2015). These rights and values locate respect as a cornerstone of nursing science, enhancing value-based health care (Thompson, McClement & Chochinov, 2011), promoting patients' health (Oosterveld-Vlug et al., 2014) and go some way to ensure patients satisfaction with care they receive (Berglund, 2007; Kahn, Iannuzzi, Stassen, Bankey & Gestring, 2015). However, respect has rarely been studied and few of these studies have assessed the respect nurses have for their older patients in relation to associated factors such as perceived health status and care satisfaction.

These associated factors become even more important when older patients are challenged by increased health problems, increased nursing needs and complex health care environments (Ausserhofer et al., 2013). Additionally, care is not always delivered respectfully (DeHart, Webb & Cornman, 2009; Buzgova & Ivanova, 2011) and many complaints focus on patient-health care relationships (Kahn et al., 2015; Harrison, Walton, Healy, Smith-Merry & Hobbs, 2016). Most of these complaints feature disrespectful communication and behavior (Reader, Gillespie & Roberts, 2014).

Respect is demonstrated within health care relationships (Dickert & Kass 2009; Koskenniemi, Leino-Kilpi & Suhonen, 2015), and is therefore a value-based, abstract concept that is difficult to measure. To circumvent this issue and because patients' perceptions of respect in nursing care are developed from their personal experiences, formal measurements of respect must use the same terms patients use to reduce misinterpretation and misunderstanding (DiBartolo, 2006; Koskenniemi et al., 2015; Koskenniemi, Leino-Kilpi, Stolt, Puukka & Suhonen, 2018).

Background

Respect perceived by older patients

The demonstration of respect forms a basis for the maintenance of value-based health care and the enhancement of the ethical quality in nursing care (Browne, 1993; Gallagher, Wainwright, Jones & Lee, 2008; Koskenniemi et al., 2015). Respect in nursing care has been defined in terms of attitudinal, cognitive and behavioral orientations towards patients (Browne, 1993; Gallagher, 2007). Respect is related to acknowledging, preserving and engaging with human worth and value (Gallagher et al., 2008) by considering patients' presence, uniqueness and individuality (Browne, 1993, Gallagher, 2007; Gallagher et al., 2008). However, respect in nursing care is seldom

investigated as an isolated topic (Koskenniemi, Leino-Kilpi & Suhonen, 2013; Koskenniemi et al., 2015; Aboumatar et al., 2015), and due to its multidimensional nature, is also poorly operationalized (Browne, 1993; Gallagher, 2008).

Respect manifests itself in relationships between professionals and patients (Dickert & Kass, 2009) and its demonstration requires nurses to explore patients' expectations, perceptions and values important to them carefully and sensitively (Browne, 1993; Gallagher, 2007; Koskenniemi et al. 2015). Respect in a patient-nurse relationship has been defined and operationalized, from the older patients' perspective, as nurses' 'being with' and 'doing for' patients (e.g. Gallagher, 2007; Koskenniemi et al., 2015). 'Being with' patients is regarded as the essence of nursing (Browne, 1995; Nolan, Davies, Brown, Keady & Nolan, 2004; Van der Elst, Dierckx de Casterle & Gastman, 2011; Koskenniemi et al., 2015) and is associated with nurses' commitment to care for older patients (Thompson et al., 2011; Moe, Hellzen & Enmarker, 2013). 'Doing for' patients is defined as nurses' actions conveying: acceptance (Jonasson & Berterö, 2012; Moe et al., 2013); listening (Jonasson & Berterö, 2012; Thompson et al., 2011); encouraging (Hellström & Sarvimäki, 2007); and nurturing (Whitbread, 2008). Respect in nurses' 'being with' and 'doing for' allows the development of a mutual understanding between patient and nurse making it possible for older patients to be more involved in their care. There are few empirical studies on the manifestation of respect in nursing care, and similarly, the factors related to respect are also rare.

Perceptions of respect in association with sociodemographic characteristics

Respect for persons is a basic right for every human being regardless of their virtue or lack of it, social position, individual characteristics or achievements, personal merit, role or power (Browne, 1993, McGee, 1994). Further, patients have the right to respect unrestricted by considerations of age, gender, disability or illness, color, creed, culture, sexual orientation, nationality, politics, race or social status (ANA, 2015).

Studies into the associations between perceptions of older age and sociodemographic factors are somewhat contradictory. Older age has been associated with increased perceptions of nursing care quality (Xiao & Barber, 2008), however, Suhonen et al. (2018) has not found this association in nursing care of cancer patients. Similar contradictory results have been reported concerning gender (Elliot et al., 2012) and marital status (Xiao & Barber, 2008). Higher education has been associated with both negative and positive ratings about the care provided by nurses (e.g. Xiao & Barber, 2008). However, little information is available on the associations between patients' sociodemographic characteristics and their perceptions of being respected by nurses and the need for these studies has been called for (Thompson et al., 2011).

Perceived respect in association with perceived health status

Health-related quality of life refers to many dimensions of health including physical, psychological and social dimensions that are affected by a person's experiences, beliefs, goals and understandings (The EuroQol Group, 1990). The experience of being respected by nurses is reported to be essential for the improvement of patients' health-related quality of life (Berterö & Ek, 1993; Buzgova & Ivanova, 2011; Koskenniemi et al., 2015). Beliefs and perceptions include the importance of being cared for as an individual, human being, and being accepted as a person, responsible for oneself and one's own decisions (Berterö & Ek, 1993). Patients expect staff to be: friendly and courteous, to converse, chat and share information, pay regard to their needs interests, habits and capacities (Berterö & Ek, 1993; Koskenniemi et al., 2015); and promote patients' perceptions of being respected by nurses (Kitwood, 1997). Ill-health-related conditions and functional incapacity have been found to threaten patients' dignity and their perceptions of self and may decrease their quality of life significantly (DeHart et al., 2009; Buzgova & Ivanova, 2011; Oosterveld-Vlug et al., 2014;

Koskenniemi et al., 2013; Koskenniemi et al., 2015). By treating patients with respect these care deficiencies could be reduced significantly (DeHart et al., 2009; Oosterveld-Vlug et al., 2014).

Perceived respect in association with patient satisfaction with nursing care

Respect conveyed by nurses is regarded an essential factor when patients' assess their satisfaction of nursing care (Johansson, Oleni & Fridlund, 2002; Berglund, 2007; Kahn et al., 2015). This respect includes: listening carefully to patients; appreciating what they say; caring about them as persons; and treating them with courtesy. These respect-related factors have been reported as promoting patients' satisfaction within the patient-nurse relationship (Kahn et al., 2015; Koskenniemi et al., 2015; Koskenniemi et al., 2018). Earlier studies have also stated that patients who are dissatisfied with their care are more often in danger of being treated disrespectfully, even abused (DeHart et al., 2009; Buzgova & Ivanova, 2011).

To summarize, previous studies about respect suggest there may be associations between perceived respect in nursing care and patients' perceived health status and care satisfaction. However, respect perceived by older patients in conjunction with associated factors such as perceived health status and care satisfaction has not been explored in a single study.

Aim

To analyze older hospital patients' perceptions of respect in a patient-nurse relationship in relation to their demographic characteristics, perceived health status and satisfaction with nursing care the following research questions were set:

- What are the levels of perceived respect, health status and satisfaction with nursing care?

- What associations are there, if any, between patients' perceptions of being treated with respect, their sociodemographic characteristics, perceived health status and satisfaction with nursing care

Methods (design, data collection and analysis)

Design

A cross-sectional, descriptive, correlational survey design using structured questionnaires was utilized to investigate the associations between the main study variables (Figure 1). Guidelines for reporting cross-sectional studies (Supplementary File 1) was used for reporting this research.

Data collection

The data used in this study has been published (REF) and has been used in this study to answer different research questions. Data were collected between February and May 2016 from older hospitalized patients (N=200) who were interviewed individually. The older people chosen were cared for in eleven rehabilitation wards in two hospitals in South-West Finland admitted with medical or surgical conditions requiring treatment or rehabilitation after surgery. Participants were recruited with the help of contact nurses in each participating ward and were eligible if they were:1) older patients (aged 65 or over); 2) in hospital for at least five days (including the admission and discharge day); 3) able to communicate in Finnish; 4) oriented in time and place (assessed by nurses) and 5) willing to participate voluntarily in the study. Patients with severe cognitive deficits, as assessed by the contact nurses were excluded.

Two researchers (JK/RH) collected the data using identical data collection procedure. The participants were asked to answer the questions from each questionnaire based on their current hospital period. Interviewers read the structured questions to the participants and documented their

answers. The response options, in upper case letters, were then held in front of the participants so that they could see and change their chosen answer if necessary.

Data collection instruments

Data were collected using three questionnaires: (1) The ReSpect Scale (Koskenniemi et al., 2018); (2) The EuroQol 5D-5L (The EuroQol Group, 1990); (3) The Patient Satisfaction Scale (Kim, 1991). The interviewers also collected patients' sociodemographic characteristics.

The **ReSpect Scale** was designed to explore patients' perceptions of respect in the care provided by nurses. The scale consists of 23 positively worded items, in two parts. The first part, 'Being with' patients (7 items) has two sub-scales. The first sub-scale examines respect in nurses' essence; (4 items relating to being: approving; an active listener; supportive; and attentive). The second sub-scale examines nurses' commitment to their patients' care; (3 items relating to being: motivated; proficient; and suited for caring. The second part, 'Doing for' patients (16 items), examines respect in nurses' actions conveying accepting (4 items relating to: acceptance; appreciated discussions; individuality; and equal treatment) listening (4 items relating to: interest in patients' perspectives; allowing time to express oneself; taking the person seriously; and understanding) encouraging (4 items relating to: positive acknowledgement; confirmation; involvement; and maintenance of hope) and lastly, nurturing (4 items relating to: availability; helpfulness; wellbeing support; and providing a caring atmosphere. The ReSpect Scale uses a Visual Analogue Scale (VAS) with a response range from 0 (never) to 100 (always). The higher the scores the more respect is perceived by the patients. In the previous study Cronbach's alpha coefficients for the total ReSpect Scale has been 0.98 overall and the two parts 0.92 (Being with) and 0.97 (Doing for). In this study the sub-scales of both parts ranged from 0.91-0.93 (Koskenniemi et al., 2018).

The EuroQol 5D-5L (EQ-5D-5L), is a generic preference-based instrument developed by the EuroQoL group and is widely used for the self-assessment of perceived health status (The EuroQol

Group, 1990; Herdman et al., 2011). The EQ-5D-5L consists of a descriptive system and a visual analogue scale (EQ-VAS). The descriptive system has five dimensions (mobility, self-care, usual activities, pain or discomfort, and anxiety or depression). Each dimension has five levels of severity: no; slight; moderate; severe; and extreme problems. The result expresses the perceived health status as a single index value (the EuroQol index) calculated from the profile. 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). In this study, the Cronbach's alpha coefficient for EQ-5D-5L was 0.79. The EQ-VAS is used to capture participant's perceptions of their current health status on a vertical visual analogue scale categorized between "best imaginable health state" (100) and "worst imaginable health state" (0).

The Patient Satisfaction Scale (PSS), (Kim, 1991), was designed to explore 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 care needs. The PSS uses a four-point Likert-type scale (1=highly dissatisfied, 2=dissatisfied, 3=satisfied, and 4=highly satisfied) and produces one score for the scale (range 1-4). The higher the score the more satisfied the patient. The original nine-item PSS has been further developed into10-item and 11-item versions by separating the ways nurses prepared patients and relatives for the hospital stay and discharge, into separate questions. The 11-item version was used in this study. The results of empirical studies using the 10-item (Suhonen, Leino-Kilpi, Välimäki & Kim, 2007) and the 11-item (Suhonen et al., 2012) PSS versions have been reported. Cronbach's alpha coefficients for the 11-item PSS total scale was 0.91 and for the subscales was 0.84-0.91 (Palese et al., 2011).

In addition, the following patients' **sociodemographic characteristics** were requested describing the participants and study context: age (in years); gender (female/male); marital status (unmarried/married or common-law/divorced/widow); living situation (alone/with next of kin/sheltered housing); basic education (primary school/secondary education); vocational education

(no vocational education/college education/ academic education); and reasons for hospitalization as perceived by the participants.

Ethical considerations

The study adhered to the principles of biomedical ethics (Beauchamp & Childress, 2013; The European Code of Conduct for Research Integrity, 2017) and was approved by the Ethics Committee of University (Statement 44/2015) and the relevant hospital authorities. The contact nurses informed potential participants of the study and asked about their desire to take part. Those willing to participate were consulted by the researcher and informed orally and in writing, of the purpose of the study. This purpose included: its voluntariness; a guarantee of the anonymity and confidentiality of the data; and the right to withdraw their consent to participate at any time without influencing their care and without having to give a reason for withdrawal. Written consent was obtained from all participants before the interview. The interviews lasted about 15 to 20 minutes, often followed by informal discussions about the research topic, which participants felt important. All participants were carefully monitored for signs of fatigue or distress during the interview and four withdrew because of tiredness.

Data analysis

The data (n=196) were analyzed using SAS 9.3 (SAS Institute Inc., Cary, North Carolina, USA) software package. Descriptive statistics (frequency, percentage, mean, standard deviation, range and 95% Confidence Intervals) were used to describe the sample and study variables. Normality was checked by Shapiro-Wilk test. A total of four sum scores were used: ReSpect total; PSS; the EQ-5D index; and the EQ VAS. The sum scores for the scales were calculated by summing the item values and then dividing the answers by the number of items. The EuroQoL 5D index was calculated by using the value weights obtained from the published United Kingdom general population scoring algorithm (EQ-5D-5L Crosswalk Index Value Calculator). The UK value set was used as suggested

by the EuroQol Group to make comparison between published studies more reasonable (EuroQoL Group, 2015).

Pearson's correlation coefficients were used initially to test the associations between the study variables. To check for non-linear associations, the perceived health status and patient satisfaction data were re-categorized into 4 equal groups, using quartiles (Q1-Q4). These groups were named poor (Q1), moderate (Q2), good (Q3) and excellent (Q4) perceived health status and satisfaction with nursing care.

The patients' reported reasons for hospitalization were classified in five groups (Table 1) based on the symptoms the patients described themselves. The t-test and analysis of variance (ANOVA) were used to study the associations between patients' background characteristics and the ReSpect scale total. ANOVA was also used to compare the quartiles of the EQ-D index and PSS. The Tukey-Kramer adjustment for multiple comparisons was used to adjust the p-values. Cronbach's alpha values were calculated to assess the psychometric properties of the scales and P-values less than 0.05 were considered statistically significant.

Results

Descriptive statistics of the study variables

The mean age of the participants was 82.1 years (range 65-100, SD=8.1). Around one third were male (33%, n=65), married (28%, n=55) and (30%, n=59) lived with their next of kin. Most participants had a primary school education (89%, n=174) as their basic education, every third participant had a college education (31%, n=74), and a minority (7%, n=13) had a university education. Around half of the participants (48%, n=94) described medical symptoms such as

dizziness, general weakness or pain, as the reason for hospitalization. Eleven patients (of 196, 6%) did not know the reason for their hospitalization. (Table 1)

Respect perceived by patients and associated factors

The mean scores (±SD) for perceived respect on the ReSpect Scale, was 76.4 (17.8), suggesting that overall, patients perceived respect in their care frequently (Table 2). Patients were quite satisfied with nursing care measured using the PSS (M=3.03, SD=0.46). The mean EuroQol 5D index was 0.60 (0.26) and EQ VAS score 56.4 (18.2), indicating average perceived health status.

No statistically significant associations between any of the patients' sociodemographic characteristics (Figure 1) and patients' perceptions of respect were found (Table 1). However, some trends could be found. Participants in the oldest patient group (86-100 years) were perceived to be most frequently respected by nurses compared to the younger groups. Further, male participants, married, living with next of kin and having a secondary education, felt respected by nurses most frequently. A variation in perceived respect between different patient groups, based on the reasons for hospitalization (ranges: M=70.4-78.2, SD=12.5-24.0) was also found. Participants who were not able to give the reason for their hospitalization (6%, n=11) gave the highest scores for perceived respect while participants who went through surgery gave the lowest.

There was a statistically significant high and positive correlation between patient satisfaction ($r=0.75$, $P<0.001$) and perceptions of respect, and a moderately significant positive correlation between perceived health (EQ-5D-5L, $r=0.30$, $P < 0.001$) and respect. A small but statistically significant positive correlation was also found between health status ($r=0.15$, $P=< 0.05$) and perceptions of being respected by nurses (Table 3).

To achieve a better understanding of the associations, the sum scores of the EQ-5D index and the PSS were examined in quartiles (Table 4). After this examination a statistically significant difference between perceived poor health status and all other health quartiles was detected. There

were no significant differences between any other health status or satisfaction quartiles. This indicates that participants with poor health status perceived respect was received less frequently. An interesting finding is that where better health status was perceived, moderate, good or excellent, there were no significant differences in perceived respect received.

Discussion

The measurement of respect as an abstract concept in nursing care is challenging (Browne, 1993; Aboumatar et al., 2015; Koskenniemi et al., 2018) and has rarely been a main topic of investigation. This empirical study has overcome some of this challenge, reducing the gap in the research literature about the respect in care delivery and its associations with older people's perceived health status and satisfaction with nursing care.

In the nursing literature respect is usually associated with human values such as respect for dignity (Coventry, 2006), autonomy (Welford et al., 2010) and integrity (Teeri et al., 2006). In this current study, perceptions of respect were considered and measured in the context of the patient-nurse relationship, as patients' perceptions of nurses' 'being with' and 'doing for' patients. On the one hand, measuring patient perceptions of respect, a value-based judgement, limits making firm empirical conclusions and extrapolating the study results to different contexts and larger populations. It follows that currently, it may be too challenging to measure all aspects of respect. On the other hand, given the fundamental value of respect in nursing and right of patient to receive it, behaviors that demonstrate respect need to be become known and understood by nurses to improve the delivery of respectful nursing care and thus, increase respect as perceived by older patients. By coming to know and understand the factors related to perceptions of respect, it may be possible to make this abstract concept more visible to nurses.

The need to investigate patients' sociodemographic characteristics in association with their perception of respect has been reported (Thompson et al., 2011). An important finding of this study was, that no statistically significant associations were detected between patients' perceptions of being respected by nurses and any of the patients' sociodemographic variables. It may suggest that the instrument used to measure the level of respect was not sensitive enough, this time to the participants' sociodemographic characteristics and any of their associated factors. This cannot be verified without further studies.

In this current study, the participants with a poor health status perceived respect less frequently than patients with a better health status. One explanation for this could be that the participants correlated their poor health with the nursing care they received which has been reported earlier (Xiao et al., 2008). There are other examples of this type of occurrence. Patients with mobility difficulties and poor self-care abilities have felt they don't receive enough help and were thus disrespected. (Moe et al., 2013; Koskenniemi et al., 2015). There have also been reports of patients with a better health status projecting their sense of wellbeing on to the care they received (Farley et al., 2014). Patients who feel healthy and comfortable, might be more likely to participate in surveys and give higher assessments of care received (Farley et al., 2014). These findings indicate that patients' perceptions of respect may not be closely associated with the measurable respect indices used but rather the patients' needs concerning their health-related wellbeing. This interpretation is supported by the results of this study, which show that patients with better perceived health (moderate, good or excellent) perceived higher levels of respect.

Poor health status is often associated with dependence, lower levels of care activities and involvement in care decisions (Moe et al., 2013). This may lead nurses to think that, because patients cannot do things by themselves, their opinions do not matter (Hellström & Sarvimäki, 2007). To respond to this challenge, disassociating themselves from the link between poor health and disregarded opinions, nurses need a caring attitude and use sensitivity and attentiveness to

identify patients whose opinions may be being disregarded. This caring attitude could then be used to exalt the identified patients' expressed and unexpressed needs (Jonasson & Berterö, 2012; Oosterveld-Vlug et al., 2014; Koskenniemi et al., 2015) Using these skills and behaviors, nurses should strive to find a competent and ethical balance between encouraging patients in their activities and assisting them in required ways (Koskenniemi et al., 2013; Oosterveld-Vlug et al., 2014; Koskenniemi et al., 2015).

Care satisfaction is regarded as an outcome of good quality nursing care (Johansson et al., 2002; Harrison et al., 2016). In this current study, a strong positive correlation between care satisfaction and perceived respect was found. This result could be interpreted in two ways. Firstly, dissatisfied patients may assess care more critically than satisfied patients. This dissatisfaction could be attributed to personal characteristics or previous poor experiences of nursing care. (DeHart et al., 2009). Earlier research suggests that dissatisfied patients who make their dissatisfaction known could get better care, or they could be treated disrespectfully (DeHart et al., 2009; Budzova & Ivanova, 2011). The delivery of respectful nursing care means that both non-demanding and demanding patients receive due respect. Secondly, in this current study, respect for patients in nurses' 'being with' and 'doing for' played a crucial role in patients' assessments of their care satisfaction, supporting earlier research (Dickert & Kass, 2009). This result would occur if items measuring respect and satisfaction were perceived to have shared or overlapping meanings. However, it is important to keep in mind the importance of sensitivity and respect in nursing care which may be able to mitigate the impact of deleterious complications or malpractices in care (Kahn et al., 2015).

Nurses have a special role in managing the level of respect for their patients within care, because they are the largest group of health care professionals who meet patients' care needs over each 24-hour period in different health care environments (Nolan et al., 2004; Koskenniemi et al., 2015). Most patient complaints are focused on the relationships between health care professionals and

patients (Harrison et al., 2016) and more specifically on disrespectful communication and behavior (Reader et al., 2014). Policy papers have highlighted patient-centeredness, the importance of patients' views and their involvement in health and social care planning, demonstrating respect for patient initiatives (WHO, 2015). To be able to enhance respect within value-based health care it is important to obtain patients' perspectives on care they receive and use reliable instruments to evaluate it. The results of this study suggest that the ReSpect scale shows promise, could be a promising instrument, able to identify respect in the patient-nurse relationship. The current study sheds light on older patients' perceptions of respect and associated factors, raising its profile and facilitating its identification and measurement, which may lead to improved respectful encounters in the workplace.

Limitations and strengths

The study data in this study were collected rigorously during a 4-month period by two researchers (JK/RH) after training together on how to use the instruments during the interviews. The study was conducted using face-to-face interviews making sure that any visual or motor difficulties, which might be general among older people, were mitigated (Peel & Wilson, 2008). The health status and care satisfaction instruments used in this study, were chosen carefully based on their validity and reliability in studies including older patients in various care settings (e.g. Herdman et al., 2011). The ReSpect scale has also been rigorously developed and tested on older patients' views. In these tests, the psychometric properties of the ReSpect scale proved to be good and the criterion validity was supported (Koskenniemi et al., 2018). However, although the instruments used were valid and reliable, the results must be interpreted with caution. Perceptions of being respected by nurses are patients' personal views and maybe not easy to identify in the structured items of the ReSpect scale. More robust testing procedures may need to be used to test the validity and reliability of the 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. Additionally, the study was

fairly small and conducted in two Finnish hospitals in one urban area. Although the participants represent older patients being cared for in rehabilitation wards and suffering with a range of health care problems the associations found here are preliminary and the results are not generalizable to larger populations. Finnish population is homogeneous, and in future it will be interesting to test the instrument and analyse results in cultures with diverse population and cultural backgrounds.

Conclusion

Verification of associations between concepts is a basic step towards theory generation. Further empirical research is needed to analyze the preliminary associations found in this study, using multivariate analyses and larger populations, to test and further develop the theoretical construction and current understanding of respect and its associated factors.

Relevance to clinical practice

Respect for patients is a fundamental professional value, a patient's right and one of the cornerstones of nursing care. The perceptions identified in this study adds to the nursing literature about respect, especially the portfolio of essential guides in the relationship between nurses and their older patients. The identification of factors associated with respect may help to identify, measure and maintain respect in the care of older people, making it more visible. Moreover, the results of this study have relevance for health care leaders who wish to enhance value-based nursing care by using quality of care instruments in health care practice.

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