Seniors' Perceptions of Respectful Nursing Care During Admission to

Acute Care

Psychiatric Units

BY

Thomas Peter Dawson
BSN, The University of British Columbia, 1996

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<u>Abstract</u>

Seniors who have a mental illness are a particularly vulnerable population. Not only do they have to cope with the incapacities caused by their mental illness but may also suffer societal discrimination because of their age and being mentally ill. These two forms of discrimination are known as ageism and stigma of mental illness respectively. Both of these two phenomena devalue a person and create feelings of low self-worth. The opposite however, can be attributed to respect, which bestows value on the person. It is therefore, reasonable to speculate that respectful care may counter the negativities of discrimination and thus play an important part in promoting health in mentally ill seniors.

This qualitative study explored whether seniors who were admitted to an acute psychiatric unit received respectful care from nurses and what the indicators of respectful care were for these seniors. Semi-structured interviews were conducted with five seniors who had experienced an admission on an acute psychiatric unit. Interpretative analysis was used to identify common themes in the participants' descriptions of respectful nursing care.

The findings suggested that all five participants felt they received respectful nursing care; no incidents of disrespectful nursing care were identified by the participants. Four themes relating to respectful care emerged from the findings. The first three themes related to indicators of respectful care: courteousness, attentiveness to patients' needs and treating patients as people. These three themes appeared to acknowledge and sustain the participants' individuality. Participants felt that nurses displayed genuine interest in them as people while being attentive to their needs. A fourth

theme, which appeared to be an antagonist to respect, was conceptualized as "too busy"; participants described how indicators of respect diminished during times when the nurses' workload appeared to increase. Participants did not blame nurses for the reduction of respectful care during these busy periods.

Recommendations for nursing practice, education, policy and research are described in the final chapter.

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Chapter One

Background to Study

The idea for this study originated in my belief that all people should be treated with respect. During the course of my nursing practice, I have tried to provide care that is respectful of patients and their families. In my experience, most people reciprocate the respect they are shown thus creating an atmosphere of mutual respect. It is my opinion that respect promotes self-esteem and ensures that patients are treated in a humane and ethical manner. After examining the nursing literature, I have concluded that respect is one of the foundations upon which nursing practice is based and merits further exploration. Because respect and dignity appear to be closely related, both are examined in the literature review.

Drew (1986) reports that dignity promotes feelings of comfort and reduces anxiety; and alternatively, that disrespect and lack of dignity create anxiety, fear and low self-esteem in patients. Respect may play a major role in promoting wellness by providing several positive outcomes, including the promotion of self-esteem and self-worth. Steckler (1990) suggests that disrespectful nursing care is seldom intentional; rather, it is due to a lack of awareness by nurses regarding how their behavior is perceived. Steckler believes nurses should be more cognizant of their actions and develop a greater understanding of what others perceive as respectful care. Morrison (1997) argues that the literature related to patients' perceptions of nursing care is insufficient and that nurses would be well advised to reflect more carefully on what patients tell them. Morrison concurs with several other nursing scholars (Kelly 1990, Browne 1993, 1995,

1997, McGee 1994 & Haddock 1996), who argue that respect and dignity have not been adequately defined or researched.

This study will focus on hospitalized seniors with a major mental illness. This particular population was chosen for two reasons. First, there were no studies found exploring respectful nursing care with respect to this population. Thus, there exists no evidence as to whether the study population perceives nursing care as respectful. Second, there exists overwhelming evidence of generally held negative attitudes toward seniors (Bythway, 1995; Hobman, 1996) and the mentally ill (Leete, 1992; Sayce 1998). Because these discriminations subsume attitudes and beliefs that are disrespectful, there is a high risk that the study population will receive disrespectful care.

The Senior Population

It is estimated that people over 65 years of age make up 13 percent of the population of British Columbia (BC) (BC Ministry of Health & Ministry Responsible for Seniors, 1996a). This figure is expected to rise partly as the result of an increase in life expectancy and partly because of the increasing age of a large cohort known as "baby boomers" (BC Ministry of Health & Ministry Responsible for Seniors, 1996a). In fact, "the seniors population is growing at more than twice the rate of the child and youth population. . . . The most rapid growth will occur in the old-old population (85 years and over), which will increase by 99% from 1996 to 2011" (BC Ministry of Health & Ministry Responsible for Seniors, 1996b, p.3). The majority of seniors enjoy a reasonable standard of health; however, as one grows older, the likelihood of experiencing ill health increases. Indeed, it has been found that the elderly occupy more hospital beds than any other age group and that, once admitted, spend longer periods of time in hospital (Greater

Vancouver Regional Hospital District, 1993). Due to the wide range of health problems experienced by seniors, nurses are likely to care for elderly patients both in extended care and acute care areas of hospitals. Specific knowledge and skills are necessary to deliver expert care to the elderly. These skills and knowledge need to be learned by all nurses who care for seniors.

Mental Illness in the Elderly

For some seniors, the stigma of mental illness increases the prospect of discrimination and disrespect. According to the Canadian Medical Association, "30% of elderly persons require mental health services" (cited by Health & Welfare Canada, 1991, p.10). Mental illnesses in seniors run the gamut of psychiatric disorders afflicting the general population, including depression, schizophrenia, bipolar disorder, and chemical abuse. Statistics Canada (1997) reports that more than one-third of hospitalized women over the age of 75 suffers from a mental disorder. In addition to these chronic, debilitating mental health disorders, the elderly are also at greater risk of developing dementia, especially of the Alzheimer's type (Schultz, O'Brian, Bookwala & Fleissner, 1995). By the year 2011, the number of seniors with dementia in British Columbia is expected to reach 66,424 -- a 60% increase over the 1996 level (BC Ministry of Health & Ministry Responsible for Seniors, 1996b). If life expectancy rates continue to climb, these figures may run even higher since the prevalence of dementia increases exponentially with age (Schultz, *et al.*, 1995).

Advancing age has also been shown to increase the risk of depression (Health & Welfare Canada, 1991). The incidence of depression for the over 65-year-old Canadian population is estimated at 9.7 percent (Health & Welfare Canada 1991). The following

risk factors have been identified as contributing to mental health problems in seniors: bereavement, social isolation, physical disability, low socio-economic status, stressful life events, long-term hypnotic drug use, sensory deficits, and genetic vulnerability (Health & Welfare Canada, 1991). Mentally ill seniors must deal with the effects of their illness and often with negative societal attitudes toward aging and mental illness.

Detrimental Attitudes: Ageism and Stigma of Mental Illness

Ageism

Though in recent years societal attitudes toward the aged have improved, the elderly remain vulnerable to stereotypical images, such expressions as 'feeble-minded' and 'debilitated' constituting common epithets (Butler, Lewis & Sunderland, 1993). According to Bytheway (1995) 'ageism' was coined by fellow sociologist, Butler in 1969 to describe a complex of negative attitudes and practices that serve to discriminate against the aged. Butler and Lewis (1973) define ageism as ". . . the systematic stereotyping of and discrimination against people because they are old. . . Old people are categorized as senile, ridged in thought and manner, old fashioned in morality and skills" (p.22). Comfort (1997) defines ageism more forcefully as "the notion that people cease to be people, cease to be the same people or become people of a distinct and inferior kind, by virtue of having lived a specified number of years" (p.35). Bytheway (1995) notes two consequences of ageism:

> Ageism reinforces a fear and denigration of the aging process and stereotyping presumptions regarding competence and the need for protection. . . . [it also] legitimates the use of chronological age to mark out classes of people who are systematically denied resources and opportunities that others enjoy, and suffer the

consequences of such denigration, ranging from well-meaning patronage to

unambiguous vilification (p.14).

In his dissertation, the sociologist Lohmann (1997) reports that, "[A]geism is expressed in

a wide variety of phenomena including negative attitudes, personal avoidance, derogatory

jokes, or institutional discrimination" (p.37). Lohmann goes on to suggest that ageism

promotes stereotypical images of older people, allowing the elderly to be viewed by the

young as essentially different from themselves and making it possible for the young to

avoid dealing with the reality of ageing.

As members of society, nurses, too, are likely to harbor 'ageist' beliefs and

attitudes detrimental to elderly clients. A number of studies show that the majority of

nurses prefer not to care for the elderly, and that geriatrics enjoys less prestige compared

to other areas of nursing (Reed & Bond, 1991; Reed & Watson, 1994). For Hobman

(1996), a former director of Age Concern in England, ageism is not a thing of the past. He

insists that discrimination against older people is rife in healthcare, and that much of this

discrimination stems from prejudice on the part of health care professionals.

The Stigma of Mental Illness

According to Goffman (1963), the term 'stigma' is derived from practices

employed by the ancient Greeks:

> [The] Greeks, who were apparently strong on visual aids, originated the
>
> term stigma to refer to bodily signs designated to expose something
>
> unusual and bad about the moral status of the signifier. The signs were cut
>
> or burnt into the body and advertised that the bearer was a slave, a
>
> criminal, or a traitor -- a blemished person, ritually polluted, to be avoided,

especially in public places (p.1).

While modern western societies prohibit branding, those viewed as odd, different or deviant are nonetheless stigmatized, singled out for humiliation and discrimination. A British study by Read & Barker (1996) suggests that discrimination towards the mentally ill remains widespread.

Just as ageism is viewed as detrimental to the elderly, the stigma of mental illness is equally harmful in that it enhances the vulnerability of seniors so affected. Historically the mentally ill have been stigmatized (Dubin & Fink, 1992). The source of this stigmatization is not only lay people with little understanding of mental illness, but professional health-caregivers (Dickstein & Hinz, 1992). Fink and Tasman (1992, p.xi) define stigmatization of mental illness " as the marginalization and ostracism of individuals because they are mentally ill". The stigmatized are in a sense dehumanized since they are denied the respect offered others. The experience of being stigmatized can lead to feelings of powerlessness, inadequacy, and low self- esteem (Leete, 1992). Such negative feelings often stem from psychiatric illness. Stigmatizing such vulnerable people, moreover, may compound their symptoms. Link, Struening, Rahv, Phelan and Nutbrock (1997) view stigmatizing as a form of negative labeling capable of " . . . trigger[ing] powerful expectations of rejection that in turn erode confidence, disrupt social interaction, and impair social and occupational functioning"(p.179). A study by Wahl (1999) suggests that, "negative responses to people identified as having a mental illness are seen as a major obstacle to recovery, limiting opportunities and undermining self-esteem" (p.467). In the same study, of the 1,301 mental health consumers surveyed, 60% (780) reported feeling shunned or avoided because they had been labeled mentally

ill. Sadly, these same respondents reported no difference in attitude between mental healthcare workers and the general population. An earlier study by Link, Mirotznik and Cullen (1991) investigating coping strategies employed by mental health patients discovered that many in the study sample admitted to concealing the fact they had received treatment for a mental illness owing to fear of rejection. Many of these same participants admitted that keeping their illness a secret caused stress. Sayce (1998) suggests the term 'stigma' be replaced with the more accurate term 'discrimination'. In his view "terms such as 'stigma' render the act of unfair treatment invisible" (p.18). Sayce believes that by using the term 'discrimination', we more accurately identify the harm society inflicts on people perceived as different. He further points out that 'stigma' connotes self-blame or humiliation, as if the individual should feel guilt, whereas in the case of discrimination, fault lies exclusively with those who discriminate. An earlier work by Hayward and Bright (1997) question the causes of stigma. In the case of mental illness, it was found that "… sufferers . . .were seen as more responsible for their conditions, as likely to be regarded with anger rather than pity, and as less likely to induce charitable behaviour" (p.352). The authors went on to conclude that many of the 'lay public' believed that the "… mentally ill choose to behave as they do" (p.352).

Leete, an advocate for the mentally ill, states that being treated with "compassion and respect, as an individual with strengths and weaknesses, instead of a mental patient who can never improve, is important" (1992, p.24). Seniors suffering mental illness risk the stigma of both age and mental illness, a dual impediment that may be extremely damaging. In my view, providing respectful nursing care to mentally ill seniors can reduce the negative feelings associated with the above stigma and promote self-esteem

and dignity. Roper and Anderson (1994) argue that "because stigmatized persons live outside the mainstream, they deserve special attention to assure they receive quality health-care"(p. 294)

Problem Statement

The dual stigmas of ageism and mental illness render mentally ill seniors especially vulnerable to disrespect. To reduce the negative impact of these stigmas, nurses need to cultivate a positive attitude toward their patients. If it is true that respect reduces anxiety, promotes feelings of comfort and enhances self-esteem, then respect may have a major role to play in promoting wellness in this vulnerable population.

Few nursing studies have been published on the subject of respectful care. Even less available is literature pertaining to seniors' perceptions as to what constitutes respectful care. To date, no studies exploring either the experience of seniors with mental illness or their views regarding respectful nursing care can be found. Thus, there exists a need to clarify what constitutes respectful and dignified care for this population.

Purpose of the Study

The purpose of this study is to investigate the perceptions of seniors, diagnosed as mentally ill and residing in acute psychiatric care units, regarding the respectful care delivered by nurses.

Research Questions

1) How do seniors describe the respect component of nursing care delivered during their admission to an acute psychiatric care unit?

2) What do seniors who are hospitalized for a mental illness perceive to be indicators of respectful nursing care?

3)What do seniors who are hospitalized for a mental illness perceive to be indicators of disrespectful nursing care?

Significance

The dual stigmas of mental illness and age may make mentally ill seniors especially vulnerable to disrespect. By providing respectful care, nurses can play a significant role in reducing the negative impact of these stigmas. Furthermore, according to the Canadian Nurses Association (CNA) Code of Ethics (1997), nurses are obligated to show " . . . respect to all human beings" (p.6). To fulfill this obligation, nurses must be cognizant of how patients define respect and to understand those nursing actions that promote respect. It is hoped that the findings from this study will provide insight into how mentally ill seniors perceive respect and disrespect. Armed with this knowledge, nurses can enhance their sensitivity regarding respectful behaviour toward this population. This investigation will also add to the limited knowledge of respectful nursing care and, hopefully, provide the groundwork for further studies in the area.

Summary

This chapter has provided background information for this study, including the key role played by respect in nursing care. A discussion of how stigmatization based on age and mental illness generates feelings of vulnerability among mentally ill seniors and how such feelings may lead to disrespect was also included. The purpose of the study, along with three research questions, was outlined.

Chapter Two

Literature Review

Introduction

In this chapter the concept of respect, as discussed in the literature, is examined. The philosophical underpinnings of respect are discussed with a view to demonstrating how it is fundamental to providing humane care. A review of discussion papers defining respect within the nursing literature is provided. The close linkage between the concepts of respect and dignity is also examined. Given their close relationship, nursing literature pertaining to the concept of dignity is also examined. Evidence that nursing theories and conceptual nursing models incorporate the concept of respect is included to demonstrate that the concept is inherent in nursing practice. Nursing studies evaluating respect and dignity are discussed with particular emphasis on those focusing on seniors. It should be noted, however, that an extensive literature search found no articles that investigated either respect or dignity in the context solely of mentally ill seniors.

The Philosophical Underpinnings of Respect

An early and significant discussion of respect is found in Immanuel Kant's Discourses on Deontology (1804/1964). Kant held that people are bound by certain moral duties, and that these must be carried out in order to be morally right. Kant believed that we must respect all that is valuable and that all humans are valuable. Other philosophers have held similar beliefs, viewing the provision of respect to all persons to be a moral duty (Peters, 1961; Downie & Telfer, 1969). John Stuart Mill (1957), a proponent of utilitarian ethical theory, emphasized that autonomy is an important constituent of respect, adding that respecting a person is a moral obligation which should be ignored

only if to do so causes harm to others. Downie & Telfer (1969) hold that respect is clearly

different from honor, esteem and admiration, as these accolades are generally credited to

those who have performed some signal action or feat; whereas respect should be

attributed to everyone simply because they are human. For this reason, Downie and Telfer

have identified the concept of respect as the central moral attitude from which all other

moral principles can be explained. Beauchamp and Childress (1989) maintain that respect

" . . . involves treating agents (persons) so as to allow them to act autonomously" (p71).

More recently, the philosopher Klutgen (1995) has expressed the view that autonomy is

an important element of respect, declaring that respecting a person includes accepting that

individuals have a right to make decisions for themselves and that consideration for their

values and beliefs ought to be shown whether or not we share them. Respect compels us

to behave in a fair and reasonable manner toward others. Important nursing principles and

values, such as autonomy and caring have, as their foundation, the concept of respect

(Klutgen, 1995).

Defining Respect and its Relationship to Dignity and Caring within Nursing

Nursing researchers Browne (1993, 1995, 1997), Stephen (1994), Kelly (1990)

and McGee (1994) suggest that it is important to clarify concepts that are fundamental to

the nursing profession. Stephen (1994) points out that respect like other fundamental

notions is difficult to define. McGee views respect as critically important, arguing that " .

. . respect permeates nursing practice, education and research . . . and that . . . nursing

care without respect dehumanizes patients" (p.681). Stephen's selectively reviewed the

nursing literature with a view to identifying various attributes of the concept. The latter

were found to include, maintaining a nonjudgmental attitude; giving respect

unconditionally; valuing clients as worthy of care; and showing consideration by validating their feelings.

Examination of the literature reveals a strong connection between the concepts of respect and dignity. Biley (1992), for example, explored the concept of dignity by obtaining written definitions from 20 student nurses. Interestingly, the term 'respect' occurred no less than 17 times. Mairis (1994) identifies three critical attributes of dignity: "maintenance of self- respect; maintenance of self-esteem and appreciation of individual standards". The fact that respect, or in this case self-respect, is considered a key attribute of dignity leads one to believe that the two concepts are closely related. It is because of this linkage that the concept of dignity is explored in the literature review.

Kelly (1990), who views "respect and caring to be the ethics and essence of nursing" (p.67), provides several propositions delineating the relationship between the concepts of respect, caring and nursing. Three of these propositions are further indicators of the fundamental importance of respect within nursing: (i)"Respect precedes caring in the nurse-client relationship; (ii) In the absence of respect, caring cannot take place; (iii) In the absence of caring, nursing cannot take place" (p.73). In support of these propositions, Kelly (1991) conducted a qualitative study aimed at identifying concepts central to the professional values of 12 English nursing undergraduate students. It was found that participants cited two primary concepts: caring and respect. In 1992, Kelly repeated her study, this time with a sample comprising 23 undergraduate nursing students from the United States. Interestingly, once again these same two concepts were cited. Attributes of respectful nursing care identified in both studies (1991& 1992) include listening to patients; providing information and explanations; talking to patients as

equals; providing choice; ensuring privacy while providing intimate care and addressing patients by their proper name or title. In addition, study participants sensed that well-intentioned terms of endearment -- e.g., "honey", "sweety", "dear" -- directed at patients by nursing staff were perceived by the former as disrespectful.

Browne (1993, 1995 & 1997), has made several contributions toward clarifying the meaning of respect within the context of nursing practice. She concedes [1993] that "initially, the effort of defining respect may seem rhetorical: its meaning is often implicitly assumed" (1993, p.211). She goes on to assert that "on closer examination . . . respect emerges as a fundamental and essential aspect of nursing practice" (p.211). Both Browne (1993) and McGee (1994) concur that there exist no instruments or criteria for measuring or evaluating respect. Browne (1993) attributes this, in part, to the fact that the concept of respect is still at an early stage of development. In a later work Browne (1997) postulates that " . . . attempting to incorporate operational indicators of respect into a standardized measurement tool might fail to capture the context of the interaction and may provide only a limited and superficial perspective of respect" (p.777). Browne's 1993 discussion paper aimed at clarifying the meaning of respect divides the manner in which respect is shown into three components: non-verbal messages, verbal messages and nursing actions. In addition to identifying attributes similar to those cited by Kelly, Browne includes making eye contact; non-threatening posture; friendly facial expression, sensitive use of touch; tone of voice and expressions of honesty.

Browne (1995) also explored the meaning of respect from the perspective of five Cree-Ojibway people. This small qualitative study involved in-depth interviews with the respondents, all of whom resided in a First Nations community in northern Manitoba. The

purpose of the study was to elucidate the informants' understanding of respect and their experience of being treated with or without respect, as the case may be, by health care professionals. Browne describes her study as ethnographic in origin, that is, oriented toward obtaining descriptions that reflect the perspective of those within the culture. Browne goes on to state that "this method of data collection is particularly useful when there is limited knowledge of the phenomena under study and the researcher is interested in description and meaning" (p.99) from within the culture. Findings from this study provide what she terms "characteristics of being shown respect" as understood by the informants as well as "characteristics of being shown disrespect". The informants identified the following attributes as indicative of respect:

1) "Capacity to treat people as inherently worthy and equal in principle. .

2) . .acceptance of others. .

3) . .willingness to listen actively to patients. .

4) . .attempts to understand patients and their unique situation. .

5) . .attempts to provide adequate explanations.. and

6) ..sincerity during interactions" (p.101-103).

Not surprisingly, the characteristics of disrespect were, in essence, the antithesis of the above:

1) ". .discriminatory attitudes. .

2) . .failure to consider the patient's perspective. .

3) . .failure to provide privacy for patients. . and

4) . .failure to provide adequate explanations" (p.104-105).

In her summary, Browne (1995) states that " the characteristics of respect derived

from informants' descriptions of respectful interactions suggest that respect has tangible

observable indicators that patients can discern in the behaviors of nurses and other health-

care providers" (p107). As a follow up to this study, the author (1997) analyzed respect,

employing the hybrid model of concept development. The latter is predicated on three

disparate disciplines: the philosophy of science, hospital field research and the sociology

of theory construction. Browne (1997) conducted an observational study of interactions

between health-care professionals and their clients. This study was carried out in a large

teaching hospital located in the northeastern United States. This site was chosen because

of its non-dominant multicultural patient population. Patient-care provider interactions,

which took place in individual examination rooms and adjacent corridors of the hospital,

were observed five hours each week over the course of six weeks. Unstructured

interviews with patients were also held in order to elicit the meaning of respect from the

patients' perspective. The majority of the patients were Spanish-speaking; a few hailed

from Southeast Asia, Portugal and Armenia. Interpreters were used during the interviews.

Incidents marked by both respect and disrespect on the part of health-care professionals

were observed. Findings from the study suggest that the following actions promote

respect:

> the provider's verbal and nonverbal attempts to connect with the patient on a
>
> human level, especially in the initial period of the interaction . . .
>
> Acknowledgment and acceptance of the patient's cultural orientation . . .The
>
> provider's attempt to protect the patients sense of human dignity . . .
>
> Acknowledgment of the patient's capacity for self-determination (p.768-772).

According to Browne (1997), incidents marked by disrespect were related to negative

stereotyping on the part of health-care providers as well as to a lack of both dignity and autonomy. Browne goes on to provide a conceptual definition of respect:

> Respect is a basic moral principle and human right that is accountable to the values of status equality among persons, human dignity, inherent worthiness, and self-determination. As a guiding principle for actions toward others, respect is conveyed through the recognition and acknowledgment of the above values in all persons. As a primary ethic of nursing, respect forms the basis of our attitudinal, cognitive, and behavioral orientation toward all persons, and is most obviously demonstrated in the manner with which one person treats another during direct interactions (p.777).

Although nursing has begun to define the concept of respect, it is clear that further work is required to provide a measurable definition acceptable to nursing science. However, the above authors (Browne, 1993, 1995, 1997, Stephen, 1994, McGee,1994, & Kelly, 1990, 1991, 1992) concur that respect has observable attributes and that the concept is fundamental to good nursing care.

Respect in the context of Nursing Models and Theories

A review of the literature reveals that several nursing scholars believe it critical to incorporate the concept of respect when formulating conceptual nursing models. In A Theoretical Framework of Interpersonal Relations for Nursing: a Conceptual Frame of Reference for Psychodynamic Nursing, Peplau (1952) holds that the central feature of nursing practice is the nurse-patient relationship. Underscoring this view, the author (1992) states " . . . the behavior of the nurse -as- a-person [sic] interacting with the patient-as-a-person [sic] has a significant impact on the patient's well-being and the

quality and outcome of nursing care" (p.14). Peplau cites as a key assumption in her model of nursing care the notion that: "clients or patients are persons who, simply because they are human beings, merit all of the humane considerations: respect, dignity, privacy, confidentiality, and ethical care" (1992, p.14). In <u>Conceptual Framework and Theory of Goal Attainment</u>, King (1990) examines several assumptions about nurse-client interactions. One assumption is that health-care professionals should provide adequate information to clients so that they can play an active role in deciding on an appropriate course of treatment. This assumption clearly demonstrates a respect for the client as an autonomous individual. As was previously stated, autonomy represents a key feature of the concept of respect. In <u>Human Science and Human Care : Theory of Nursing</u>, Watson (1985) also argues that nurses should value human autonomy and freedom of choice, adding that nurses must treat themselves with dignity if they are to treat others with respect and dignity. Watson (1988) stipulates that for nursing, caring is a moral ideal that should promote human dignity. Likewise, Parse (1992), in her <u>Nursing Theory of Human Becoming</u>, recognizes that the nurse should "respect the individual's or family's own view of quality [of life] and . . . not attempt to change that view to be consistent with his or her own perspective" (p.39)

Campbell's (1987) <u>UBC Model for Nursing</u> includes respect as one of the nine basic human needs that individuals constantly strive to satisfy. Campbell's model is a systems model, wherein the individual is viewed as an aggregate of nine subsystems (p.9). One, labeled the ego-valuative subsystem, requires "respect of self by the self and others" (p.38). According to Campbell, the ultimate goal of seeking respect is for the system to achieve "self-esteem" (p.38). Accordingly, nurses who subscribe to the UBC

Model for Nursing require a thorough understanding of the concept of respect if they are to assess fully client needs and provide purposeful nursing care.

Seemingly, respect is a fundamental concept within nursing, permeating as it does a number of nursing theories and models. Nurses wishing to predicate their practice on one of the aforementioned models require a clear understanding of the concept of respect.

Nursing Research on Respectful Care

Nursing researchers have sought not only to define respect, but also to measure whether the concept is evinced in nursing practice. The earliest nursing study of respectful care found in the literature is by Wagnild and Manning (1985). This observational study sought to ascertain whether nursing aides in long-term care facilities provided respectful care during bathing procedures. The researchers observed the bathing procedure of 42 residents residing in 6 long-term care facilities. An observation checklist was used to measure the quality of nursing aide interactions with the residents during bathing. The checklist included six observational categories pertaining to: how the resident was addressed; explanations and preparation; use of touch to expresses reassurance or concern; whether eye contact was initiated; whether the nursing aide engaged in conversation with the resident; and whether the resident was provided privacy during the bathing procedure. The study revealed that several of the nursing aides used terms of endearment such as "honey" and "sweetie" in place of Christian or surnames. However, 74 % were addressed by their surname. Only 33% were provided with explanations or received any form of preparation prior to bathing. Conversation was initiated in only 50% of the bathing procedures. Eye contact was frequent in the case of only 50% of the nursing aides with 29% making no eye contact. Appropriate touching

was initiated by 69% of the nursing aides, the remaining 31% touching residents only during the bathing procedure. A major violation of respect was the lack of privacy provided during the bathing procedure. Of the 42 residents, only 6 (14%) were bathed in privacy while the remaining 86% were bathed with at least one other nursing aide and resident present. Wagnild and Manning obtained further data by interviewing the residents following their bath. When questioned, all expressed satisfaction with the procedure. The researchers suggested that the residents may have felt comfortable with the predictable routine rather than with the procedure itself. Wagnild and Manning also opined that, as they were strangers to the residents, some of the responses may be a form of " . . . acquiescence on the residents part" (p.9). The researchers went on to suggest that bathing two or more residents in a community shower may lead to depersonalization in addition to " . . . withdrawal, low morale, and anxiety" (p.9). The need to promote a sense of identity among the residents was stressed by the authors, who state that meaningful interaction is " . . . crucial for their (residents') wellbeing" Wagnild and Manning's (1985) study provides observable data indicating instances of lack of respect on the part of several nursing aids. When questioned, however, none of the residents reported dissatisfaction with the bathing procedures. Inconsistency between the observed data and this response suggests that to obtain a full understanding of the phenomenon, researchers should query participants under non-threatening circumstances. It is possible that the indicators for respectful care used by Wagnild and Manning differ markedly from those of residents.

The following year, Drew (1986) conducted a phenomenological study that examined distressing and nurturing experiences with caregivers. Drew's contention is that

impersonal care, regardless of how professional the delivery, is negligent as it depersonalizes the patient. Drew goes on to suggest that depersonalization of an individual makes him feel "objectified" (p.40) and unimportant. The study consisted of 13 male and 22 female participants ranging from 20 to 79 years of age. All were surgical or gynecological patients receiving treatment at a community hospital in the United Sates. Audio-taped interviews were conducted with each subject. The opening question asked: "Can you describe one positive and one negative experience with a caregiver?" (p.40). Findings from the study suggest that participants felt excluded when caregivers withheld "emotional warmth" (p.41) by acting in a "superior, disinterested, dismissive, insensitive and preoccupied . . ." (p.41) manner. They also indicated a sensitivity to the caregiver's tone of voice, facial expression, and level of eye contact. Negative experiences with caregivers produced feelings of " . . . fear, anger and shame . . ." (p.41). The experience proved positive when health-care staff worked in a calm, less hurried fashion, joked with the patient and appeared interested in the patient and in his or her care. The tone of voice during positive interactions was described as "low, modulated [and] . . . animated . . . " (p.42) and charged with emotional warmth. Positive experiences with caregivers resulted in patients' experiencing "hope, comfort, confidence, and assurance, and a sense of ease and relaxation" (p.42). Drew concludes that providing positive care that confirms the patient's existence can promote wellness by allowing him or her to direct energy to the task of healing and recovery.

Although the study does not speak of respect directly, it is apparent that behaviour which promotes positive interactions between patient and caregiver is indicative of respect. Drew's (1986) contention that positive experiences with care-givers promote

feelings of wellness provides a further impetus for nurses to provide respectful and dignifying care.

Steckler's (1990) study was designed " . . . to determine whether elderly clients in an acute care hospital setting perceived if they were treated with dignity and respect and whether some elderly clients were more likely than others to be treated with dignity and respect" (p.10). Employing a descriptive and correlational design, the study sampled 62 subjects. Steckler's criteria for choosing subjects included the following: the subject must be aged 65 years or older; be fluent in English; have completed a hospital stay of five days or more in a medical or surgical ward; and been interviewed within three days of discharge. Structured interviews were conducted using selected items from the Hegyvary and Hausssman's 1975 Medicus Quality Assurance Tool (MQA). Questions excerpted from the MQA were intended to elicit whether clients were adequately oriented to the facility, ensured privacy, asked to approve procedures, provided relevant information, addressed by their proper name[s] unless otherwise requested, and offered an opportunity to discuss their concerns. As these were all closed questions, they could be easily quantified. Findings from the study suggest that elderly patients often experience disrespect from nursing staff. Disrespect was evinced by the following behaviours: failure to provide adequate orientation to the hospital environment; failure to provide explanations for procedures; and a propensity for addressing elderly patients by their first name without first seeking permission. As previously mentioned, it is Steckler's belief, though unsubstantiated in this study, that much of the disrespect shown by nurses is due to a lack of awareness as to how their actions, or lack thereof, are perceived.

A Heiselman and Noelker (1991) study examined mutual respect between nursing

assistants on one hand and residents and their families on the other. The study was conducted at a long-term care facility housing 37 residents and employing 40 nursing assistants. A semi-structured interview was employed, featuring both closed and open-ended questions. The interviews were aimed at elucidating the residents' and nursing assistants' understanding of respect and collecting data on how respect and disrespect are experienced by the two groups. The findings suggest that 30% of the nursing assistants experienced what they termed disrespect in the form of " . . . verbal abuse and insults from residents" (p.553). This group also reported that family members and relatives had questioned them regarding care "in a tone of voice implying they [were] guilty of neglect or incompetence" (p.553). In contrast, 94% of the residents reported that the nursing assistants provided gentle care; 91% " . . .that the assistants seemed to enjoy helping residents" (p.553). There is clearly a marked difference between residents' perceptions of respect and those of the nursing assistants. This dichotomy may be due in part to differing perceptions of the role played by nursing assistants (Heiselman & Noelker). Ninety-five percent of the nursing assistants expressed the view that " . . . they expect to be treated like family by residents, . . . whereas only half the residents share these expectations" (p.554). Almost 50% of residents indicated the need to maintain a modicum of social distance between themselves and the nursing assistants. Congruence with respect to role perception may play an important part in determining whether someone feels respected. It must be remembered, however, that this study drew on a small sample from a single institution. Additional studies examining the relation between role expectation and respect would help clarify the relationship between these two variables.

A study by Morris (1997) evaluated the care offered in family planning clinics

across the United States. As part of this study the author developed a tool for measuring

respectful care. Morris believed that patient satisfaction would increase if patients were

treated with respect and that there may be a relationship between respectful treatment and

health outcomes. While Morris admitted that it was difficult to operationalize the concept

of respect, the study team " . . . finally defined respectful treatment as behavior which

accords the patient high status in a sociological sense" (p.138). In other words, "the more

the patient was treated with consideration, as if he or she were of high status, the more

respect was illustrated in the behavior" (p138). Two variables were identified as bearing

on respectful care: the first concerns the interaction of staff with patients; the second the

quality of the environment in which these interactions take place. Data for program

evaluation was collected from 37 clinics in 10 cities across the US. Study design

included a two part "Clinical Observation Record (COR)" (p139) and a " . . . self-

administered instrument for measuring patient satisfaction (PATSAT)" (p.139). The first

part of COR evaluates the personal behavior of the health-care staff participating in the

program. Each staff member was observed interacting with five different patients. The

purpose of the observations was to obtain an objective measure of the level of respect

shown each patient. A 24 item checklist of behaviors was used to record staff-patient

interactions. COR items included: the introduction of staff to the patient; introduction of

the observer to the patient; obtaining permission from the patient regarding the observer's

presence; the staff's tone of voice; and whether staff used "value statements". Morris

admitted that COR is " . . . not a direct measure of behaviors which patients had shown to

prefer" (p.139). He also warned that " . . . patients unaccustomed to being treated in a

manner the research group defined as respectful, might feel uncomfortable when treated

that way" (p.139). It is possible, therefore, that COR does not measure what the patients regard as respectful care. The second part of COR evaluates the clinic's physical environment as well as clinic policies and procedures. Questions asked included the following: Does the layout of the clinic provide patients with privacy?; What amenities -- e.g., adequate lighting, space, restrooms, and reading materials -- are provided?; Is the clinic clean and sanitary? Policy items Morris believed to be indicative of respectful treatment included the level of staff qualifications; the suitability, with respect to patient needs, of operational hours; and the length of time patients were required to wait for appointments. The final phase of data collection employed PATSAT, which was voluntarily completed by the patients prior to discharge. PATSAT features five fixed-choice questions, each with a five-point scale. The questions were designed to ascertain whether patients were satisfied with the length of their stay, services received and quality of care. Also included were open-ended questions aimed at generating specific details regarding compliments or complaints about the clinic and/or staff. While a total of 1,173 patients undertook to complete the PATSAT questionairre, there was a low response rate to the open-ended questions. Findings from the COR section of the study reveal that patients were rarely introduced to staff, rarely addressed in a respectful manner and never asked whether they objected to the presence of an observer (p144). The majority of patients, however, received the contraceptive method of choice and were engaged in a respectful tone of voice. PATSAT scores indicate that the major cause of dissatisfaction lay in what were perceived as long waiting periods. According to PATSAT, explanations and treatment provided by staff accounted for most of the patient satisfaction. Based on these findings, Morris suggests that health-care programs adopt the following objectives:

first, eliminate excessive waiting periods as these suggest to patients that their time is not valuable; second, ensure that patients are treated with respect by staff; third, provide an environment designed to promote privacy, convenience and comfort; and, finally, evaluate on a regular and frequent basis interactions between staff and patients. As with the previous studies, Morris' findings suggest that there are behaviors, which are perceived as either respectful or disrespectful, and that there is ample scope for improvement in the way in which health-care staff interact with clients.

Summary

In this chapter the philosophical underpinnings of respect were discussed, and the nursing literature related to this concept reviewed. The literature review suggests that, in the context of nursing care, at least, respect and dignity are interwoven and, therefore, difficult to examine in isolation. In addition, it was demonstrated that other important nursing concepts -- dignity, caring, autonomy -- are all closely linked to respect. Nursing theories that incorporate the concept of respect were identified, providing evidence that the concept is an integral part of nursing care. Only a few studies were found that explored respect in the context of caring for seniors.

Conclusion

The concept of respect is an important factor in health-care delivery. Several major nursing theories and models, predicated on the inherent worth of the individual, incorporate attributes related to the concept of respect. Some researchers have attempted to define respect in order to study its attributes in the context of nursing practice. On the basis of the literature review, the following appear to be the chief components to respectful nursing care:

(i)   respect for all;

(ii)   equal treatment for all;

(iii)   exercise of non-judgmental attitudes towards others;

(iv)   maintenance of autonomy;

(v)   genuine interest in others; and

(vi)   recognition that every person's time is valuable.

It is clear, however, that further study of the concept in relation to the perceptions of specific populations is required. Certainly, vulnerable populations such as the mentally ill and elderly require further study to determine whether both feel respected. Owing to the indignities of ageism and the stigma of mental illness, such populations may require special attention to ensure they receive respectful nursing care

Chapter Three

Methodology

Owing to the dual stigmas of ageism and mental illness, mentally ill seniors may be especially in need of respect from others. By providing this population with respectful care, nurses can play a significant role in reducing the negative impact associated with these stigmas. Achieving this goal requires nurses to be knowledgeable about how mentally ill seniors perceive respect in the context of nursing care. The purpose of this study is to investigate the perceptions of seniors, admitted to acute psychiatric units, regarding respectful treatment by nurses. Towards this end, three research questions have been formulated:

> i) How do seniors describe the respect component of nursing care delivered during their admission to an acute psychiatric care unit?
>
> ii) What do seniors who are hospitalized for a mental illness perceive to be indicators of respectful nursing care?
>
> iii) What do seniors who are hospitalized for a mental illness perceive to be indicators of disrespectful nursing care?

Research Design

This study employs an interpretive methodology involving the qualitative data collection technique of the personal interview. Interpretive research is qualitative and inductive in recognition of the " . . . constitutive cognitive processes inherent in all social life" (Lowenberg, 1993, p.58). According to Payne (1999), the qualitative interview centres " . . . on the respondent's life-world . . . and therefore . . . seeks to understand the meaning of the phenomena from his perspective" (p.90). Streubert and Carpenter (1995)

inform us that interpretive methods of research are useful assuming life experiences are the best source of data given the phenomenon under investigation (p.35). As participant perceptions of life experiences are the central focus of this study, an interpretive approach is deemed appropriate.

Assumptions

The following assumptions inform this study:

1) Participants are able to articulate their perceptions of the phenomena under study.

2) Participants can identify what constitutes respect and disrespect

3) Participants will provide truthful data in the knowledge that their anonymity will be protected and without fear of recrimination.

Limitations

1) As the study investigates phenomena solely from the point of view of the participants, both the attitudes of nurses and quality of nursing care can only be inferred.

2) For this study convenience sampling was employed. Some patients were excluded on the grounds that they had recovered insufficiently to provide informed consent or lacked full command of the English language. As the sample may not be typical of the population, generalizations cannot be made.

Sample

The sample consisted of seniors who were receiving, or who had received, treatment for a mental disorder in an acute psychiatric care unit. The term "mental illness" as used here refers to any disorder recognized by the American Psychiatric

Association's Diagnostic and Statistical Manual of Mental Disorders (1994) as an "Axis I" disorder

Criteria for sample selection include:

1) a minimum age of sixty-five years;

2) currently undergoing treatment for a mental illness in an acute psychiatric inpatient unit or discharged from an acute psychiatric unit within a six week period of the interview;

3) fluency in the English language;

4) willingness to participate; and

5) capacity to give informed consent, as indicated by an ability to explain, in his or her own words, the purpose of the study.

Interpretive research allows anyone who has lived the experience in question to qualify as a subject (Field & Morse, 1985). Convenience sampling was used for this study. This method employs the most readily available subjects that satisfy the above criteria (Polit & Hungler, 1991, Burns & Grove, 1997). The sample size in interpretive research is determined by the richness of the data and the participants' ability to respond to questioning. Sufficient numbers are thus reached when distinct themes are identified, and the experience is understood. It is usually the case with in-depth interviews that the sample size ranges between 4-15 participants. The sample size for this study was 5.

Recruitment

Approval for the study was given by University of British Columbia's Behavioural Research Ethics Board. Once approval had been granted, a Community Mental Health Services (CMHS) branch in a large Canadian city was approached with a request to

recruit subjects from among its clients. Permission to conduct the study was obtained by

submitting a letter to that effect (Appendix A) followed by submission of a CMHS

application form pertaining to the research and protection of human subjects. CMHS

approval allowed access to Community Mental Health Teams (CMHT). Having liaised

with several of the teams heretofore in my capacity as a psychiatric nurse, I found

approaching them a relatively easy task. The CMHTs are multi-disciplinary teams of

mental healthcare professionals -- nurses, psychiatrists, occupational therapists, social

workers -- that provide community mental health care services. Assistance was sought

from six CMHTs. A letter of introduction, describing the study and requesting assistance,

was posted to each team (Appendix B). This was followed by an information meeting

with the respective CMHT staff. The meetings provided an opportunity to discuss the

study as well as a forum for fielding questions. Third party recruitment was used. This

method relied upon CMHT staff to select from their case list candidates who met the

above criteria. These were then approached by staff and briefed regarding the study. In

addition, each potential subject received a letter outlining the study (Appendix D). These

same clients were then asked whether they were interested in participating in the study.

Names and contact numbers of interested clients were then forwarded to me. After

introducing myself to the candidates, I provided a thorough explanation of the study and

fielded questions. Consent was sought only after I was satisfied that the candidate fully

understood what participation involved and was willing to participate. To ensure full

understanding, I asked each to describe in his-own words what the study involved. All

signed and received a copy of a consent form (Appendix E). As a means of promoting

recruitment, frequent contact with the teams was maintained via telephone and personal

visits.

Surprisingly, very few clients volunteered to participate in the study. In fact only five participants were recruited over a seven-month period. However, these five provided insightful observations regarding respectful nursing care. It is not clear why recruitment for the study was so low, but could be partly due the sample criteria. For instance, several CMHT staff members informed me that many of the mentally ill seniors in their care are cognitively impaired and thus ineligible for the study. Another reason for low recruitment may have been a reluctance on the part of some seniors to participate in the study. Such reluctance may stem from the stigma of mental illness -- a stigma that would cause some patients to prefer anonymity. In order to increase the number of participants, the over sixty-five age range was relaxed to allow one sixty-four year old to participate. It was felt that this candidate was sufficiently close to meeting the age criterion that his inclusion would not skew the data.

Data Collection

Semi-structured interviews of approximately one hour in duration were used to obtain data. Trigger questions focused on the participants' perceptions of their interactions with the nursing staff (Appendix C). All the interviews were audio-taped, coded and transcribed onto computer disk. Questions continued to develop as the study progressed and common themes were identified. A follow-up interview with one of the participant's was conducted to confirm that I had correctly identified what the participant intended to communicate, to clarify any areas of uncertainty and to share common themes. Participants were given the choice as to where they would like the interviews to be conducted. The first two were held in the respective participant's home, the following

three at an acute psychiatric unit of a metropolitan teaching hospital. Two of the hospital

interviews were conducted in an office, the third in the participant's private room.

Data Analysis

Content analysis was used to identify themes emerging from the data. The data

analysis began with the researcher actively listening to the participants' during the

interview. By listening to the audio-taped interviews whilst reading the transcribed text

the researcher became immersed in the data (Streubert & Carpenter, 1995). Similarities

and differences among the participants' descriptions were identified. Common themes

were identified and categorized. Polit and Hungler (1991) state that "a theme might be a

phrase, sentence, or paragraph embodying ideas or making an assertion about some topic"

(p.510). Polit and Hungler go onto suggest that placing the themes into categories creates

a more objective and systematic study. Verification of these themes was sort during the

follow-up interview.

Validity and Rigor

To ensure that the study was conducted rigorously, the researcher followed Burns

and Grove's (1997) guidelines, the purpose of which is to foster open-mindedness and

objectivity by identifying and letting go of assumptions. It is important for the researcher

to guard against preconceived ideas and personal values as these can influence how data

is analyzed. The researcher must also guard against asking leading questions. Therefore,

trigger questions (Appendix C) were so designed as to elicit from the participant only his

perception -- not that of the researcher -- of how the phenomena in question was

experienced. It was hoped that by impressing upon participants the fact that their

confidentiality would be honored and that all data obtained in the study would be reported

as themes and aggregated data, they would feel comfortable and talk candidly about their experiences. At the end of the study, the findings were validated by feedback received from one of the participants (Burns & Grove, 1997).

Protection of Human Subjects

Participants were initially approached by a CMHT staff member and provided a brief explanation of the study, along with a letter introducing the researcher, i.e., Peter Dawson (Appendix D). After being introduced to a participant, I described the study in greater detail and answered any questions or concerns regarding the process. To ensure informed consent, all participants were required to provide an accurate explanation of their role in the study. Assurances were given that any decision concerning their participation would in no way impact their care, now or in the future. Participants were informed that they may choose to leave the study at any time or refuse to answer specific questions. Signed consent forms were obtained from each subject prior to participation (Appendix E). A copy of the signed consent form was given to the participant. The consent form further stipulated that findings from the study could be published and/ or used for educational purposes. Assurances regarding confidentiality were given and explained. Audio-tapes from the interviews were coded so that only the researcher could identify the participants. The codes were stored separately and were not used during data analysis. A third party was hired to transcribe the recordings but had no access to the identity of the participants. All findings are reported in aggregate. The audio-tapes and transcripts will be destroyed once the study and scholarly work have been completed.

Permission to conduct the study was also obtained from the University of British Columbia Ethics Committee as well as from the Community Mental Health Services

Ethics Committee.

Summary

This chapter has discussed the study's purpose, design, sampling method, and methods of data collection and analysis; issues of validity, reliability and protection of human subjects were also explored.

Chapter Four

Findings

Introduction

The findings of this study are divided into two sections: the first provides a description of the participants; the second, a discussion of the themes that emerge from the subjects' descriptions of respectful nursing. Sufficient interpretation is included to place participants' statements in context.

Description of Participants

Five participants were recruited from four mental health clinics located in the Greater Vancouver Metropolitan Area. Participants ranged in age from 64 to 84, with a mean age of 75.4, and a standard deviation of 6.437. All but one were Caucasian; the fifth was of Chinese origin. Three of the participants were female; two were male. The Axis I disorders attributed to the participants were as follows: three were diagnosed with uni-polar depression, one with bipolar disorder (hypo-mania) and one with conversion disorder. Length of hospitalization ranged from 4 to 22 weeks, with a mean of 11 weeks, and a standard deviation of 5.440. For four of the subjects, this was a second psychiatric admission; for the fifth, a third. One participant had been discharged five weeks prior to the interview; a second was currently attending a day program, having been discharged from an inpatient unit four weeks previously; the remaining three were interviewed immediately prior to discharge from the hospital. Two of the participants had been certified under the British Columbian Mental Health Act but were decertified before the time of the interview; the remaining three were voluntary admissions. For two of the participants, this was their third admission to an acute mental health care unit; for the

remaining three, a second. At the time of the interviews all five were in a recovery stage, were oriented to time, place and person, and were able to provide informed consent. The investigator followed the consent procedure as specified in Chapter Three.

Themes Emerging from Descriptions of Respectful Nursing Care

Analysis of the data reveals that all the participants had some conception of what constitutes respectful nursing care. Three themes related to respectful care emerged from the analysis of the data: courtesy, attentiveness to patient needs and treating patients as people. A fourth theme also emerged from the analysis. Labeled "too busy," it is treated here as an antagonist of respect.

Courtesy

Courtesy is defined in the Collins Cobuild English Language Dictionary as " . . . behaviour that is polite, respectful, and considerate . . . "(1992, p.325) Participants repeatedly referred to such acts when describing respectful care by nurses. Participants described how courtesy on the part of nurses occurred early on in interactions with them and continued throughout all of the exchanges.

Participants viewed courtesy as an important component of respectful care. Courteous nursing behaviours included respecting a patient's right to privacy and autonomy by seeking permission before entering his room. One participant said:" [W]ell they knock on the door before they enter the room . . .". Another said: "I found the nurses very polite. They would never barge in on you when you were in your room".
Interestingly, participants cited similar behaviour when describing how they, themselves, demonstrated respect to others. One participant declared: "I always ask if I can sit down . . ."; another that "I asked permission to just sit down, and do you mind if I put my tray

here?"; yet another said " . . . and so I just ate with them and asked them first if it was okay". These exchanges exemplify seeking permission to share personal space.

Courtesy was also evinced by what can be called polite verbal interactions between nurses and participants. As one participant noted, "[A]nd they (the nurses) always used 'please' and 'thank' you". Other nursing behaviors described as courteous include inquiring of participants as to their well being and acting in ways that acknowledge their presence. As one participant observed, "When they (the nurses) see me, they wave"; another said that: " . . . there is always a smile that makes you feel good"; yet another said, "When the nurses see you even when you're just passing, they speak to you and say good morning or hello"

Attentiveness to Needs

Participants felt that respectful nurses were attentive to their needs. In fact, when discussing respectful care, all five mentioned some aspect of personal care provided by nurses. The Collins Cobuild English Language Dictionary defines attentiveness as someone being "very helpful and polite to someone else, often because they like them very much . . . "(p. 81, 1992). The dictionary also features several definitions for the term "need" including: " . . .1.1 you must have it because it is a basic necessity and because you depend on it in order to live and be healthy . . . ". Attentiveness to needs includes, among other things, the seeking of information about the physical and psychological state of participants as well as communicating a willingness to do something about it. Citing an example of attentiveness to needs, one participant recalled that, "They would give me Tylenol for my headache when I asked for it". Another provided this observation about the attentive care received from nurses: "They call us. Here is your medication, and they

call out and say breakfast is here". A frail 76-year-old commented, " They would come and ask me if I wanted a drink or a snack. Sometimes they would bring me some ice cream. I think they were trying to build me up. I'd lost some weight before I came into hospital, but I think I have put on a few pounds since coming here (hospital)". One participant requiring considerable help with the activities of daily living remarked:

> "They asked if I needed anything. If I want my bed made. You know, I was disabled with conversion disorder, so I could not walk very well, and they always asked me if they could put my tray on the table, or when I come up with a cane even when I was feeling pretty good and got stuck somewhere and needed my walker, they would go get it for me".

The same participant stated: "I couldn't do sometimes by myself, so the nurses would do it for me, or take me down to do it in a wheelchair, which was, you know, above and beyond the call of duty". One participant underscored what respectful care meant for him thus: "Yeah, and they just kind of made sure you got what you wanted". Attentiveness to needs also included anticipation of need, as indicated by this participant's comment: "Yes that's right they (the nurses) were so helpful. They often would know what I wanted even before I did if you know what I mean".

Respectful nursing care was also discussed in the context of attentiveness to non-physical needs. As one participant stated,

> . . . and just the handling of that, how they did it, was pretty good, because I didn't think I had time in my life for mental illness, and anybody that had mental illness was a little different from me, so it was us and them, and the nurses still gave me full respect and helped me with it. They asked me if I ever needed to

talk, to go to them, and to make sure I wasn't shy about it, they would take me on

the side and asked me if I want to talk about anything, and it was really good, and

after a month or so, I just went up the next rung as far as the mental health issue

goes because of the nurses and the doctor, of course

In this instance, the nurses recognized the participant's need to come to terms with his

illness and encouraged him repeatedly to discuss concerns regarding his diagnosis. The

participant seemingly found the nurse's approach non-threatening respectful and

therapeutic.

People need to feel that they are of value. This is especially true for seniors and

for those with mental illness. Participants described how nurses were attentive to this

need by showing interest, concern and tolerance. As one 84 year old remarked: "I have

never had the feeling that their thoughts are somewhere else". Such behaviours

demonstrate respect because patients are made to feel that their opinions and concerns are

important. As one participant recalled, "I felt respected, when they (the nurses) showed

that they were concerned about me and the other patients and that they had concern and

tolerance when someone was being difficult". Regarding tolerance, this 76 year old

further noted, " Oh they were great, never getting upset. Sometimes the person (a patient)

would become very difficult and angry. I thought the nurses behaved well [as] they never

lost their temper". Finally, one participant, observing other patients receiving care,

commented,

> "[A]nd in one case, there was someone in a wheelchair, not a wheelchair, a
>
> walker, wearing diapers, a grown person, and the nurse would go in their
>
> (i.e., the patient's) room and check on them like every hour or so and kind

of ask them if they needed to be changed or something like that, and it

wasn't like somebody trying to send somebody to do their job, they just did

it. I was totally impressed with that".

Observing other patients receiving care may have instilled confidence in this participant

by reassuring him that he too will receive attentive care.

Treating Patients as People

The theme of treating patients as people, in the view of participants, encompasses

a number of nursing behaviours, including treating patients as individuals, showing an

interest in them as people, promoting equality, and maintaining an appropriate degree of

informality. Four of the five participants cited instances when they felt nurses had

recognized them as individuals. One participant recalled: "Well, one would come into the

room that we went into to have our conversation with the doctor, and she (the nurse) was

there, and just made me feel like a person, or something". Another included the

following in his description of respectful nursing care: "People are people, and just

treating you like a human being, just letting you coexist or whatever, not forcing you to

do anything is very important". This last statement captures the critical importance of

equality and autonomy. This same participant went on to suggest the need to treat people

as equals in declaring that, " Just not putting the person down, treating him as an equal as

far as a person goes, but not an equal as far as medicine goes. I think you get a lot further

treating people better, so you get respect both ways". This last statement suggests the

participant believed that respect begets respect. A further comment by this same

participant seems to support the notion that genuine concern for the patient as a person

may have a role to play in providing respect: "There was one thing they did was to make

you feel comfortable, so you could talk and you knew they weren't laughing at you, that they took you seriously." Another participant also found that nurses took an interest in her as a person remarking, "Yes, they talk about my life, all about my children and grandchildren, and how I feel". All participants reported positive interactions with nurses, one participant commenting on how she enjoyed the nurses sharing something of their personal lives: "Yes I felt respected when they (the nurses) shared things about themselves; it made it easier to talk to them about myself".

According to the participants, a degree of informality on the part of nurses was both forthcoming and appreciated. One participant seemed to welcome nurses taking the initiative in establishing a rapport, remarking, "They come and talk to you. They show interest in your person". The following statement from another illustrates an act of kindness and thoughtfulness on the part of two nurses: " They were very nice to me. Always encouraging and telling me I would get better. Two of them bought me some cake on my birthday". The following comments suggest that participants felt at ease with the nursing staff: "But it is the way that it is conducted (nursing care), and they conduct it very nicely". One participant, though hospitalized against her will, nonetheless appreciated efforts on the part of nursing staff aimed at putting her at ease, noting, "It was like talking to a friend. You know, like talking with a friend". Seemingly, involuntary admission to hospital is not necessarily a barrier to respectful nursing care. Participants also seemed to enjoy nurses interacting with them. Explained one participant: "You know, they (the nurses) would be asking me how I was feeling. Some of them would tell me a joke or discuss something that was happening in the real world, such as stories that were on the news". This last statement suggests the participant enjoyed a certain level of

informality with nurses. Simple friendly gestures appeared to make a significant difference;: as one participant explained, "Oh yes they all seemed to really care. Even when they were busy, they always said hello or gave me a smile".

Another mark of informality was addressing patients by their first name. Surprisingly, the seniors participating in this study seemed to prefer being addressed by their first name rather than a surname/family name and title, e.g., Mr. or Ms. Being addressed, thus, appeared to promote the perception of being treated as a person. Such informality may have also helped create a friendlier social environment, as illustrated by the following exchange:

(Interviewer): "Were you ever asked by the nurses how you would like to be addressed?"

(Participant): "No, I wasn't asked, and they all call each other by their first name".

(Interviewer): "Do you like that"?

(Participant): "Yeh, it's like (being) included into a circle".

One participant, though comfortable at being addressed by her first name, suggested that she may have preferred her surname/family name being used, remarking, "[N]o. Well I guess I think if they were calling me Mrs. . . . all the time or something, it would have been nice. But, no, I don't feel it is wrong that they are being more friendly and easier with me if they call me by my first name." This somewhat qualified statement notwithstanding, none of the participants objected to being addressed by their first name. This finding contradicts the literature previously cited in this study, posing an issue that will be addressed in the following chapter.

Treating patients as people is a common theme that all but one of the participants identified as a crucial element of respectful nursing care. Included in this theme are the

concepts of equality and autonomy.

"Too Busy": an Antagonist of Respect

When questioned about disrespectful care on the part of nurses, none of the participants could provide concrete examples; in fact, none recalled any treatment that might be perceived as disrespectful. Though aware of no instances of overt disrespect from nurses, participants did perceive a reduction in the level of respect shown them on those occasions when nurses appeared busy. One comment, in particular, illustrates this phenomenon: "I think if they had more time, they would be more respectful like". This same respondent went on to declare, "It is just that sometimes I would like to get hold of them and ask them more questions like. I don't seem to get much chance to really talk to them". Similar views were voiced by a second participant who remarked, " . . . I would have liked more time with them, you know, but when they were so rushed, you did not like to hold them up. They were still nice, you know, but everything was done so quickly". The following statement suggests the participants did not blame the nursing staff on these occasions: "But, I must say I definitely know, I watch them, and I am on the sidelines watching them, that they are rushing around some of them, just positively rushing around to get to what they have to do with the patients and that"; another remarked, "Well they seemed in a rush you know. I don't think it was their fault. There seemed a lot for them to do". However, more than a hint of frustration on the part of one participant could be discerned in her complaint that, "It is often difficult to get their attention".

This last section has focussed on the perception that during periods when nursing staff appear busy, respectful care diminished. This is not to say that patients were treated

disrespectfully during such periods, only that instances of respect were less evident. Participants indicated that there were fewer opportunities to ask questions of nurses and that the latter appeared to be "rushing" to complete their work.

Summary

This chapter has identified and examined themes emerging from an analysis of data collected during the course of interviews with five participants. A description of the participants was included so as to provide context for the analysis. The first theme, which is courtesy, was defined as a precursor of respect. The second, attentiveness to needs, was defined and described in terms of attention directed at participants' physical and non-physical needs. All the participants, it should be emphasized, identified "having their needs met" as a critical component of respectful nursing care. The third theme, treating patients as people, was explored, using direct quotes from participants. This theme centred about treating patients as individuals by promoting equality, maintaining a judicious measure of informality and showing genuine interest in patients as people. Contrary to the literature, none of the participants disliked nursing staff addressing them by their first name. Respectful nurses appeared willing to spend the requisite time getting to know the participants as people and to acknowledge their presence, sometimes merely by smiling or waving.

Lastly, while participants perceived no disrespect on the part of nursing staff, they did sense a reduction in the level of respectful care during those periods when nurses were busy. Participants did not appear to blame nurses for this diminution, however; nor, on these occasions, did they feel they were no longer being "cared for" adequately. The following chapter will discuss the above findings.

Chapter Five

Discussion and Recommendations

Introduction

In this chapter the study's findings are discussed. First, it is suggested that the

three themes central to respectful care have a common thread in that all acknowledge and

sustain the patient as an individual. Second, it is suggested that how time spent getting to

know patients, promotes respectful care is discussed. Third, the finding that participants

did not feel disrespected when being addressed on a first name basis by nurses is

examined. Fourth, the ways in which greater nursing workloads pose a challenge to

respectful care are explored. Finally, implications for the four domains of nursing –

practice, education, policy, and research – are discussed.

Acknowledging and Sustaining the Individual

For the investigator, the most striking impression to emerge from the findings was

that the three themes of respectful nursing care identified above – courtesy, attentiveness

to needs and treatment of patients as people – are equally applicable to acknowledging

patients as individuals. Participant perceptions of respectful nursing care focussed on

behaviors that made them feel both worthy and human. Participant recollections of care

revealed a conviction that being treated as both an equal and as an individual was crucial

to feeling respected.

First impressions are apparently critical in developing respectful relationships. All

the participants cite courteous behaviour early on in the nurse-patient relationship, for

instance, as contributing to their feeling respected. This lends support to Browne's (1997)

assertion that the quality of the initial contact with health professionals is an important factor in delivering respectful care.

Time spent getting to know patients appears to be a key factor in delivering respectful care. Establishing a personal relationship with patients is perhaps best achieved by means of social discourse which can take various forms: for instance, inquiring after their families, discussing current affairs, offering a limited degree of self-disclosure. Participant recollections of social discourse with nurses were invariably positive. Participants described how nurses succeeded in breaking down at least some of the formal barriers in the nurse-patient relationship. Conversing informally with patients may not appear goal directed; however, judging from participant accounts, this is when patients feel they are being treated with respect. Participants report that respectful nurses engaged in both social and therapeutic discourse. By taking the time to converse informally with patients, nurses, create a friendly and comfortable environment.

In a study exploring respect and coercion of patients in Swedish psychiatric institutions, Olofsson and Jacobsson (2001) report that patients believed "[B]eing spoken to as an ordinary person" (p.361) to be a prerequisite for creating respect. To be treated as a person helps sustain a patient's sense of individuality. Gray, Cavanagh, Mowat and Kopp (2001) stress that, "identity maintenance and the support by nursing staff are important, particularly for older people" (p.1436). To underscore this assertion, the authors contend that care should be "person-centered rather than patient-centered" (p.1436).

It is not clear from this study whether nurses intentionally use informal occasions to promote respect or whether the respect participants experienced is a byproduct of

unplanned non-goal directed informal interaction. Spending time talking and getting to know patients as a means of promoting therapeutic relationships is one approach supported by nursing researchers (McLaughlan, 1999; Gray, *et. al.* 2001, Olofsson & Jacobsson, 2001; O'Brien, 2001). Indeed, O'Brien suggests that strategies used by mental health nurses to develop therapeutic relationships should include minimizing professional roles, responding to the individual needs of patients and engaging in ordinary activities with patients. Participants in the Olofsson and Jacobsson (2001) study cite a " . . . desire to be treated by the staff as a fellow human in need of help" (p.362). These findings have led the investigator to conclude that informal social interactions between nurses and patients generate the following positive results: (i) help the nurse view the patient as unique; (ii) allow the patient to view the nurse as a person; (iii) and promote trust within the nurse-patient relationship.

Nurses in this study provided a degree of self-disclosure to patients with positive results; one participant declared that she liked self-disclosures of this type as they encouraged her to talk more freely about herself. It is important to note that the literature suggests nurses use self-disclosure judiciously, so as to ensure the patient remains the focus of the interactions. Briant and Freshwater (1998) argue that while the nursing profession asserts that the "... nurse-patient relationship is based on the principle of equality . . . it remains the responsibility of the nurse to maintain appropriate boundaries (p.204)". Participants in this study cited no over-familiarity on the part of nurses. This finding is corroborated by Forchuck and Reynolds (2001), who in their study of comparing client reflections on their relationships with nurses in both Scotland and Canada, found that although the nurse was viewed as being friendly, the relationship was

differentiated from friendship" because of the ". . . non-symmetrical nature of the

relationship . . ." (p.47). Evidently, patients recognize that while they may reveal

information of a personal nature to nurses, the latter aren't expected to reciprocate.

On First Name Terms

When asked, all the participants said that nurses addressed them by their first

name. All denied ever being asked by the staff as to how they should wish to be

addressed, however. The literature suggests that older adults prefer to be addressed by

their title and/or surname (family name). Several researchers (Wagnild & Manning, 1985,

Steckler, 1990 and Heiselman & Noelker,1992) all include the use of a title and surname

among their criteria for measuring respect. Thus, it was interesting to discover that, while

nurses addressed all the participants by their first name, none of the participants reported

perceiving this as disrespectful. In fact, one participant intimated that, being on first name

terms with the nurses made her feel " . . . like (she was) included into (sic) a circle". This

suggests that being on a first name basis may break down barriers between staff and

patients. However, as one participant did indicate a preference to be addressed as Mrs. . .

it would appear prudent for nurses to ask seniors how they prefer being addressed rather

than assume all wish to be addressed informally. Interestingly, this same participant

added that she took no offence at being addressed by her first name as she assumed the

nurses were just trying to be friendly. It should be remembered that many seniors lived

their formative years in societies that valued formal behaviour above familiarity;

accordingly, it might be more respectful were nurses to offer seniors a choice as to how

they wish to be addressed.

Increased Workload: A Challenge to Respectful Care?

One of the goals of this study was to identify what seniors who are hospitalized

for a mental illness perceive to be indicators of disrespectful nursing care. As mentioned

in the previous chapter, none of the participants identified any such indicators. However,

several indicated that when nurses appeared to be busy, fewer indicators of respectful care

were in evidence. Thus the theme 'too busy' is categorized as the antagonist of respectful

care. This study did not ascertain why the nurses were 'too busy'. It should be noted

however, that it generally accepted that the health care environment is under strain

because of inadequate resources, especially in the form of manpower. Nursing in

particular is experiencing a depleting workforce. The decline in the number of nurses

appears to be due to the large numbers of nurses who are reaching retirement age and the

fact that over years the healthcare system has not recruited enough nurses to replace those

leaving the system. By not being proactive with recruitment many Western societies find

themselves with a grave nursing shortage. Thus nurses are increasingly finding

themselves 'short staffed' that is fewer nurses are left to provide the same level of care.

Participants in the study did indicate, however, that they believed nurses were not

deliberately ignoring their needs. On the other hand, it is not surprising that indicators of

respectful care such as being attentive to patient needs and treating patients as people

were less in evidence during busy periods. Less time spent with patients diminishes

opportunities for nurses to familiarize themselves with patients, assess needs, and develop

therapeutic relationships that facilitate respectful nursing care.

According to participants, nurses, even when busy, acknowledged their presence

with gestures and smiles. These relatively simple acts may play an important role in

reassuring patients that they are still recognized, that they have not been forgotten. The sight of nurses rushing about their duties may be disconcerting for some seniors, especially those afflicted with cognitive difficulties stemming from mental illness. At least one of the five participants appeared frustrated when she found that nurses were unavailable to answer her questions.

Not surprisingly, several studies support the hypothesis that when nurses appear "too busy"(i.e., spend less time with individual patients owing to increased demands on their time), respectful or patient-focused care suffers. Several authors (McLaughlin, 1999, Olofsson & Jacobsson, 2001, Talseth, Lindseth, Jacobsson & Norberg, 1999, Wallace, Robertson, Miller & Frisch, 1999) provide evidence of patients affirming a need to spend time with nurses who were perceived to be too busy. Nurses indicated to McLaughlin (1999) that it was their non-clinical duties that impeded them from devoting more time to patients. Although not blamed by participants for being too busy, nurses should still be responsible for addressing this problem.

Implications and Recommendations

Implications and recommendations stemming from this study are addressed under the four domains of nursing: practice, education, policy and research. Implicit within the recommendations are that nurses should employ the indicators of respectful care as identified by the study's participants and that nurses should be cognizant of the fact that indicators of respectful care may diminish when their workload increases.

Practice

A major implication of this study is that nurses who care for seniors hospitalized with a mental illness should, if they wish to promote respectful care, employ behaviours similar to those described by the participants in the study. It is hoped that nurses are already utilizing these respectful behaviours in their practice. This study confirmed, that attending to patients needs in a courteous manner and treating patients as individuals does promote respect. Nurses also need to remember that first impressions are important in establishing respectful relationships with patients. In addition, the patient's right to privacy should be maintained whenever possible. Nurses should also give patients a choice as to how they wish to be addressed.

In the present healthcare environment, with its shortages in nursing staff, nurses must seek out innovative ways for establishing personal relationships with patients so that they might better understand them as individuals. This may mean giving a higher priority to building respectful relationships.

Education

Educational programs play an important role in shaping nursing attitudes and behaviours. Because respect is viewed as a fundamental ethical value (Downie & Telfer, 1969), there may be some justification in requiring student nurses to explore the concept in some depth. The development of respectful attitudes and behaviours should be of paramount importance in the education of nurses. Nursing curriculums need to foster the ideal that patients should be viewed as people first rather than being compartmentalized into medical or stereotyped categories. Strategies that promote the patient, as an individual, should be taught. This would include the indicators of respectful care

identified within this study.

With regards to caring for seniors, nurse educators must ensure that students develop an understanding that seniors are a heterogeneous group who should be treated as the individuals they are. To ensure these ends student nurses must examine their own feelings and attitudes that they foster about seniors and ageing. Exploring the discrimination of ageism will help nurses understand how it negatively impacts seniors and hopefully will encourage nurses to seek ways to counteract this inequity. Similarly nurses should be encouraged to explore their feelings and attitudes towards the mentally ill and to understand the prejudices held within society's stigma of mental illness. Thus nurses can then develop strategies to counteract the negative effects of this unjust discrimination. By gaining insight into these often-vulnerable populations nurses should be taught how to be effective advocates in order to support and represent these patients successfully.

In-service education programs on respectful care should also be provided to nurses working in clinical areas. These in-services could be customized to fit individual clinical areas. That is indicators of respectful care for specific patient populations (if different) could be taught to nurses working in that particular area. Because seniors and the mentally ill are admitted into various clinical areas in-service education about ageism and stigma of mental illness would be appropriate for most practicing nurses.

Policy

Nurses must become more involved in healthcare policy both at the meso and macro level. At the meso level nurses should advocate unit and hospital policies that promote respectful care. Such policies include ensuring patients are treated with equality,

are provided choice whenever possible; that the patients' right to privacy is protected; and that that nurses' daily activities include establishing and maintaining personal relationships with patients.

At the macro level of regional, provincial and national forums nurses should also play an advocacy role. They might, for instance, lobby for inclusion in the planning of healthcare facilities such as hospitals and clinics to ensure privacy and patient comfort are addressed and that physical space is more conducive to talking; or for policies ensuring patient-staff ratios are at levels that allow nurses the opportunity to familiarize themselves with patients; or for including respectful care as a criterion for evaluating healthcare policy. Policies that promote respect would then be more readily adopted. At present cost effectiveness and efficiencies seem to be the main criterion in the drafting of healthcare policy.

Also at the macro level nurses should take the lead in educating the public about the harm ageism and the stigma of mental illness cause. This should be coupled with exposing societal myths about ageing and mental illness and replacing it with accurate information. One way of achieving this would be for nurses to run national campaigns outlining the realities of aging and being mentally ill. Secondary to this, nurses should provide feedback to any media that misrepresents or promotes discrimination of seniors or the mentally ill.

Research

Several additional research questions emerge from this study. First, do nurses deliberately apply respectful care? Knowing the answer would help nurses devise strategies for monitoring their own behaviour with regard to providing respectful care.

The investigator suggests that further observational studies, coupled with interviews with prospective participants and nurses, may help to answer this question. Second, does respectful care contribute positively to combating discrimination stemming from ageism and the stigma of mental illness? To answer this question, structured interviews might be conducted wherein patients would be asked whether they had experienced discrimination in their respective communities and whether respectful nursing care had made a difference. Third, what strategies can nurses devise to prevent respectful care from declining during those periods when nurses are perceived as 'too busy'? Both observational studies and interviews with patients and nurses may be helpful in answering this question. Fourth, other populations should be considered for study. These might include patients in other age groups or from other cultures or areas of healthcare. With so many different cultures residing in the urban areas of Canada it is important for nurses to aware what constitutes respectful care to each of these cultures. Culture not only plays apart in the makeup of the patient population but also within the profession of nursing. That is, the present nursing workforce is comprised of many cultures. Finally, do involuntary patients require different approaches to ensuring they feel respected than voluntary patients? In this study the two patients who had been admitted involuntarily reported receiving respectful care. However, owing to the small sample size, further exploration is warranted.

Summary

This chapter has presented the study's findings. That the study's three themes were linked to acknowledging and sustaining patients as individuals was recognized. The role of non-goal directed social interaction in promoting respectful was discussed.

The one finding that contradicted the literature, i.e., that none of the participants felt disrespected by being addressed on a first name basis, was explored. This was followed by a discussion relating to how increased nursing workloads inform participant perceptions of respectful nursing care. Finally, implications and recommendations for nursing practice, education, policy and research were outlined.

Conclusion

This qualitative study shed's light on how respectful nursing care is perceived by hospitalized seniors suffering from mental illness. The five participants were able to provide rich insights regarding indicators of respectful care. The investigator is not surprised that courtesy was linked to respect. Whether courtesy is a precursor of respect or a component is arguable. Further research would help clarify this question. What is clear is that, in the case of hospitalized seniors afflicted with mental illness, behaviours associated with courtesy, attending to patients' needs and treating patients as people play an important role in the delivery of respectful nursing care.

Previous nursing scholars (Browne, 1993 & Stephen, 1994) have alluded to the fact that respect is difficult to define. For some, respect involves holding patients in high regard and treating them, accordingly, in a formal manner. Indeed, Morris's (1997) study identified the status afforded clients by staff as a measure of respect. Therefore, it is interesting that informal, rather than formal, interactions between nurses and patients were seen as an integral part of respectful nursing care. This may be partly because the term 'respectful care' is more specific than the broader concept of 'respect'.

The question of what constitutes an indicator of disrespectful care was not, indeed, could not, be addressed here. Whether this is because none of the participants

experienced disrespect or were disinclined to share their experiences with the investigator remains unclear. It is possible that these particular participants chose not to discuss this issue. Disrespectful care could simply be the antithesis of respectful care, that is, being discourteous, ignoring patient needs and refusing to treat patients as individuals may be the essence of disrespect. However, further studies would be required to test this hypothesis.

In the context of the hospital environment nurses spend more time with patients then do other health care professionals; thus, if respectful care on the part of nurses is a key factor in optimizing overall care, than it should be considered a major focus of nursing practice, education, policy and research. By adhering to the principles of respectful care, nurses will come to view and treat patients as individuals, a prerequisite for entering into a genuine and caring relationship. The investigator trusts his efforts will help promote a greater interest in and further studies of respectful care. If nothing else, the investigator trusts this study will encourage other nurses to reexamine their practice in light of the principles of respectful care.

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Appendix A

Page 1 of 2

Introductory Letter to Vancouver Community Mental Health Services

Title of Study: Seniors' Perceptions of Respectful Nursing Care during

Admission to **Acute Care Psychiatric Units**

Investigator: Peter Dawson, R.N., M.S.N. Student, Home: 604- 822-7369

Faculty Advisor: Ms. Janet Ericksen, R.N. Office: 604- 822-7588

My name is Peter Dawson. I am a registered nurse and am presently enrolled in the Master of Science Nursing Program at the University of British Columbia [UBC].

I am currently completing a Masters Thesis, investigating how mentally ill seniors perceive respectful care on the part of nursing staff. The study sample is to consist of subjects who have undergone or are presently undergoing treatment at an acute psychiatric care unit. Findings from the study may be used to increase knowledge regarding patient perceptions of respectful nursing care and enhance the sensitivity of nurses who care for seniors suffering from mental illness.

Data will be obtained from participants during personal interviews recorded on audio-tape. Participants must be over 65 years of age, have received or are currently receiving treatment for an Axis I mental illness, be capable of providing informed consent, and fluent in the English language. Community mental health teams located in the Greater Vancouver Region will be solicited to recruit participants for the study. The teams are responsible for ensuring that candidates are sufficiently recovered from their respective illnesses to participate in the study.

Patients who satisfy all criteria will be provided with a brief verbal and written explanation of the study. If a willingness to participate is indicated, the team will then arrange a meeting with the investigator. At this meeting participants will receive a full explanation of the study and provide their written consent.

Prior to initiating the study, I should like to meet with the community mental health teams to enlist their support in selecting participants in addition to discussing

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Introductory Letter to Vancouver Community Mental Health Services

any concern's they may have regarding the study. All means of identifying clients, staff or

the hospital will be removed from the transcripts and published reports

If you have any questions or concerns, please contact me or my faculty supervisor

Using the telephone numbers listed above.

Should you have concerns regarding any aspect of this study, please contact UBC

Director of Research Services Dr. Richard Spratley 604- 822-8598.

Thank you for your co-operation,

Sincerely yours,

Peter Dawson

Appendix B

Page 1 of 2

Letter to Vancouver Community Mental Health Teams

Study Title: Seniors' Perceptions of Respectful Nursing Care during Admission to an Acute Psychiatric Care Unit

Investigator: Peter Dawson, R.N., M.S.N. Student, Home: 604- 822-7369

Faculty Advisor: Ms. Janet Ericksen, R.N. Office: 604- 822-7588

My name is Peter Dawson. I am a registered nurse and am presently enrolled in the Master of Science in Nursing Program at the University of British Columbia [UBC].

I am currently completing a Masters Thesis, investigating how mentally ill seniors perceive respectful care on the part of nursing staff. The study sample consists of subjects who have undergone or are presently undergoing treatment at an acute psychiatric care unit. Findings from the study may be used to increase knowledge of patient perceptions of respectful nursing care and enhance the sensitivity of nurses who care for seniors suffering from mental illness.

Information obtained from selected participants, who have been inpatients at a psychiatric unit within the last six weeks will be elicited by means of audio-taped interviews. Participants must be over 65 years of age, currently receiving treatment for an Axis I mental illness, capable of providing informed consent, and fluent in the English language.

I am requesting your assistance in identifying potential participants. Subjects who satisfy the above study criteria should be approached by the treatment team and given a brief explanation of the study, along with a written request to participate. Interested candidates should be referred to me. I will then arrange a meeting with these candidates to explain the study and address questions and concerns. Consenting patients will be asked to sign a consent form at this time. All means of identifying clients, staff or the

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Letter to Vancouver Community Mental Health Teams

hospital will be removed from the transcripts and published reports.

It is my wish to meet with the treatment team in-person so as to answer any questions and address any concerns regarding the study. You may contact me or my faculty supervisor at the telephone numbers provided above.

If at any time you have concerns regarding any aspect of the study, please contact UBC Director of Research Services Dr. Richard Spratley 604- 822-8598.

I wish to thank you all for assisting me in undertaking this study.

Sincerely yours,

Peter Dawson, RN, BsN

Appendix C

Trigger Questions

1) How do you feel about the nursing care you received during your hospital stay?

2) Can you describe one situation during your hospital stay when you felt respected by a nurse?

3) Can you share with me other situations when you felt respected by a nurse?

4) Can you describe a situation when you felt disrespected by a nurse?

5) Can you describe any other situations when you felt disrespected by a nurse?

Appendix D

Page 1 of 2

Information Letter for Participants

Title of Study: Senior's Perceptions of Respectful Nursing Care During Their
Admission to an Acute Psychiatric Unit.

Investigator: Peter Dawson, R.N., M.S.N. Student, Phone 604-822-7369

Faculty Advisor: Ms. Janet Ericksen, R.N. Phone 604-822-7437

My name is Peter Dawson. I am a registered nurse and am presently enrolled in
the Master of Science in Nursing Program at the University of British Columbia [UBC].

I am currently completing a Masters Thesis, investigating how mentally ill seniors
perceive respectful care on the part of nursing staff. The study sample consists of
subjects who have undergone or are presently undergoing treatment at an acute
psychiatric care unit. Findings from the study may be used to increase knowledge of
patient perceptions of respectful nursing care and enhance the sensitivity of nurses who
care for seniors suffering from mental illness.

I would like your permission to interview you about the nursing care you received
during your hospital stay. The interview will last about one hour. A second interview may
be requested to discuss the findings and clarify any misconceptions that may have arisen
during the first interview. Both interviews will be recorded on audiotape and then
transcribed so that I can read over what we discussed while listening to the recordings.

The interviews will take place at your Community Health Centre or at your home
or at another location of mutual convenience and comfort. All information will remain
confidential, including the identity of the participants; All audiotapes and transcripts will
be coded to ensure confidentiality. The coded information will be secured in a locked
drawer, and the data destroyed following completion of the study, scholarly presentations
and publications. To ensure greater confidentiality, data from the study will be reported in
aggregate (as a group).

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Information Letter for Participants

Your decision to participate is strictly voluntary; any refusal on your part to participate will in no way jeopardize or influence the care you receive now or in the future. You may choose to leave the study or stop the interviews at any time. Should you have any questions or concerns, please contact me or my faculty supervisor at the numbers provided below.

Should you wish to participate, you may contact me directly or ask your nurse to inform me of your interest. If you wish information on the findings of this study, I would be pleased to provide a summary upon request.

Should you at any time have concerns about the way in which this study is conducted please contact Dr.Spratley, Director of Research Services at the University of British Columbia 604- 822-8598.

Thank you for your co-operation.

Sincerely yours,

Peter Dawson, RN, BsN

Appendix E

Page 1 of 2

Consent Form

Title of Study: Senior's Perceptions of Respectful Nursing Care During Their Admission to an Acute Psychiatric Unit.

Investigator: Peter Dawson, R.N., M.S.N. Student, Phone 822-7369

Faculty Advisor: Ms. Janet Ericksen, R.N. Phone 822-7437

Purpose:

I understand that the purpose of the study is to investigate the perceptions of mentally ill seniors regarding their experience of respectful nursing care. All the subjects having previously undergone treatment in an acute psychiatric care unit.

I understand and agree to the following terms regarding my involvement in this study:

1) I will be interviewed regarding my perceptions of the nursing care I received as an in-patient;

2) that I may be asked to participate in a second interview, the purpose of which is to clarify any misconceptions the researcher may have formed;

3) that the length of each interview will be approximately one hour; and

4) that the interviews will be audio-taped and transcribed onto computer disk.

Confidentiality:

I understand that any information obtained during the interviews will remain confidential and that the names of participants will not appear in the report or in any subsequent publications related to the study. I also understand that all audio-tapes and computer disks will be coded and secured in a locked drawer when not in use. Both audiotapes and computer disks will be destroyed once the study and presentations have been completed. and the results published.

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Consent Form

Remuneration/Compensation:

I understand there is to be no remuneration for my participation in this study.

Contact:

I understand that if I have questions about the study, I may contact Peter Dawson at 604- 822-7369 or Janet Ericksen at 604- 822-7588.

I understand that if I have any concerns about the way the study is conducted or about my rights as a research subject I may contact Dr.Richard Spratley, Director of Research Services, University of British Columbia. Dr. Spratley may be reached at 604-822-8598.

Consent:

I understand that my participation in the study is purely voluntary; that I may refuse to answer any or all questions; and that I may withdraw at any time. I also understand that any refusal on my part to participate will in no way jeopardize or influence any care that I may receive now or in the future.

I acknowledge the receipt of an explanatory letter (Information Letter for Participants), along with a copy of this consent form.

I hereby consent to participate in this study as described above.

Date:....................................

Signature:......................................

Witness:......................................