DO ELDERLY CLIENTS IN AN ACUTE CARE HOSPITAL PERCEIVE THEY ARE TREATED WITH DIGNITY AND RESPECT

by

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Abstract

The purpose of this study was to investigate whether elderly clients in an acute care setting perceived themselves as being treated with dignity and respect, and whether clients with a higher socioeconomic status are more likely than clients with a lower socioeconomic status to be treated with dignity and respect.

Sixty-two elderly clients who had been in hospital at least five days, were alert and oriented during their hospitalization, and could speak English were selected for the study. Using a convenience sampling technique, the clients were selected from medical and surgical units of two major teaching hospitals. They were interviewed within three days after discharge to respond to items on a questionnaire selected from the Medicus Quality Assurance Tool.

The results of the study show that elderly clients may not perceive that they are consistently treated with dignity and respect. Older clients (75+ years) are less likely than younger older clients (65-74) to be treated with dignity and respect, and elderly clients with a lower socioeconomic status and women, are less likely to be treated with dignity and respect.

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CHAPTER 1

Introduction to the Study

Nurses' attitudes toward elderly clients have received increasing attention in recent years. There are three reasons for this interest. First, there is an increase in the number of elderly clients who require nursing services since health service usage rises dramatically with age and there is an increase in the absolute numbers of aged (Gutman, Gee, Bojanowski, & Mottet, 1986; Roos, Shapiro, & Roos, 1984; Stone & Fletcher, 1986). While acute care hospital usage has fallen in British Columbia, this decline is not seen among the elderly (Gutman et al., 1986). Approximately 10% to 15% of all beds in acute care hospitals are occupied by elderly people waiting for placement in long term care facilities (Silversides, 1987). Second, studies show that registered nurses least prefer working with the elderly (Campbell, 1971; Smith, Jepson, & Perloff, 1982). While 74% of registered nurses work in acute care hospitals, they do not like to nurse older people (Mantle, 1988b). Third, registered nurses who hold negative attitudes toward the elderly may engage in behaviors which will not be therapeutic or may be detrimental to the best interests of the elderly client (Brower, 1981).

The elderly are not a homogenous group but differ widely in their physical and psychosocial status. Moreover,

old age is not necessarily indicative of decline. Even though obvious physical changes occur, aging need not be equated with illness or disease. As a group, however, older persons are more likely to experience multiple chronic and disabling conditions (Bossenmaier, 1982; Chappell, Strain, & Blandford, 1986). The risk with these chronic conditions and activity limitations is for further decline in function and acute exacerbation of disease (Bossenmaier, 1982; Gioiella & Bevil, 1985).

The age-related physiologic and psychosocial changes that occur also predispose the older client to risk, particularly at the time of hospitalization. For example, changes in vision, hearing, and other sensory modalities can affect cognitive function and predispose the elderly client to a state of confusion (Burnside, 1988; Chodil & Williams, 1970; Worrell, 1977). According to these authors, the individual imputes meaning to the environment through sensory interaction. Use of color, light, and texture, attention to activity and sounds, placement of equipment, furnishings, and mobility aids as well as caregiver interaction can promote or hinder meaningful environmental exchange. If the hospital does not promote meaningful environmental interaction, a frequent outcome is an acute confusional state. Confusional states in the elderly person increase the possibility for falls, incontinence, sleep disturbances and mobility, nutritional, and skin problems.

As a result, dependency and the requirement for nursing care increases.

Old age is also characterized by loss. Many hospitalized older clients have already experienced a loss of job, income, possessions, relatives, friends, and even a spouse or home. The circumstances necessitating hospitalization may mean further losses, functional ability, or independence (Burnside, 1988; Ebersole & Hess, 1985).

Together with the normal age-related changes and the multiple health problems already present, the older hospitalized client is highly vulnerable. Diminished physiologic reserves and a decreased capacity to adapt to unfamiliar surroundings are additional characteristics which further render the hospitalized older client at risk (Bossenmaier, 1982; Gioiella & Bevil, 1985). Relocating from a familiar, safe living environment to the strange, unfamiliar hospital setting that requires interacting with unfamiliar people threatens the aged person's ability to cope when hospitalization is sudden and unplanned (Burnside, 1988; Ebersole & Hess, 1985; Gunter, 1983). These authors point out that every nurse is personally responsible and accountable for nursing practice delivered to clients, and that includes elderly clients.

Nursing practice guided by models provide a certain frame of reference for nurses, telling them what to look at and to speculate about (Fawcett, 1984). Each conceptual

model has utility for professional nursing because of the organization it provides for thinking, observing, and interpreting in the use of the nursing process (Leddy & Pepper, 1985). Models also provide the nurse with a way in which to view the client, and the role and function of nursing. One such model, the UBC Model for Nursing (Campbell, 1987) is a behavioral system model made up of nine subsystems that are interrelating and interdependent. Each subsystem is responsible for the satisfaction of a basic human need.

The nine needs related to each of the subsystems include the need for (1) balance between production and utilization of energy; (2) collection and removal of accumulated wastes; (3) intake of food and fluids, nourishment; (4) intake of oxygen; (5) love, belongingness, and dependence; (6) mastery; (7) respect of self by self and others; (8) safety and security; and (9) stimulation of the system's senses (hearing, vision, smell, touch, and taste).

The client uses coping behaviors to satisfy each basic human need. Forces (as defined in the UBC Model for Nursing) determine movement toward or away from goal achievement. Goal achievement means need satisfaction.

It is important to recognize that a force (personal, impersonal, or sociocultural) may act positively toward one need and negatively toward another, and that a coping behavior which is suitable to satisfy one need may act as a

negative force in satisfying another. A force which may act negatively toward one subsystem, may also act as a negative force toward other subsystems. This notion is of particular importance when using the model to plan care for the elderly client. For example, failing to orientate an elderly client to his surrounding and introduce him to his roommates may act as a negative force not only on the Achieving subsystem, but the Ego-valuative and Protective subsystems as well.

The UBC Model for Nursing defines nursing's unique function as "nurturing individuals experiencing critical periods in the life cycle so that they may develop and use a range of coping behaviors that permit them to satisfy their basic human needs, to achieve stability and to reach optimal health" (p. 10). A critical period, according to this model, is an event occurring in an individual's life that requires the individual to develop and use suitable coping behaviors to satisfy his basic human needs. These critical periods include maturational and unpredictable events.

Maturational events are those changes which occur with some predictability during an individual's life. According to the UBC Model for Nursing, these events include body changes (change in physical structure and function), geographical change (move to a different city or neighbourhood), intrafamilial change (change within the family with respect to number, membership, or location of family members), role change, social interaction changes

(change in human relationships), or work career change. Unpredictable events are those changes which occur with little or no warning. Categories of these events may include aberrant cell growth (deviant development of cells occurring after birth), congenital disorders, circulatory disorders, degenerative processes, immunologic disorders, infectious processes, trauma, and separation (physical disconnection of an individual from significant persons or objects).

It is an ethical duty to practice nursing in such a way as to assist the elderly client who is experiencing a critical period (unpredictable or maturational) to achieve optimal health within a collaborative and caring relationship (Burnside, 1988; Ebersole & Hess, 1985; Gunter, 1983; Lueckenotte, 1987). According to these authors, negative and nonsupporting attitudes of nurses contribute to the vulnerability of the aged and affect the quality of care they receive.

Although there have been several studies that investigate the quality of nursing care the elderly receive, there has been little attention given to elderly clients' perceptions of their care. More recently, however, elderly hospitalized clients report a threat to their self-esteem when nurses' behaviors toward them indicate a lack of dignity and respect (McInnes, 1987).

Self-esteem is an inner assurance of personal worth

based on feelings of being valued, useful, and competent (Ebersole & Hess, 1985). It is the evaluative component of the self-concept. Roy (1976) defined self-concept as a combination of the feelings and beliefs one holds in regards to oneself. According to Maslow (1970), people have basic human needs and all persons "have a need or desire for a stable, firmly based, usually high evaluation of themselves, for self-respect or self-esteem, and for the esteem of others" (p. 90). Maslow identified two subsets of esteem needs: self-esteem needs (strength, achievement, mastery and competence, confidence in the face of the world, independence, and freedom), and respect needs or the need for esteem from others (status, dominance, recognition, attention, importance, and appreciation).

The elderly person may have a solid foundation in all these areas based on past achievements, present success, or personal integrity. Self-esteem, however, may be threatenend during a critical period when the elderly client is unable to develop suitable coping behaviors to meet his basic human needs for mastery (feeling of accomplishment), for love, belongingness and independence, and for respect of self by self and others (Campbell, 1987).

Background to the Study

As a result of demographic changes, the proportion of health care resources committed to the care of the elderly will continue to increase. When today's nursing students

reach the prime of their careers, they will likely spend 75% of their practice time with the elderly (Butler, 1980). Evidence indicates that attitudes nurses hold about the aged influence the quality of services they provide (Hatton, 1977; Wolk & Wolk, 1971).

Certain perceptions held by nurses adversely influence the nursing care the elderly receive. The elderly are generally perceived by younger people as physically and mentally on the decline, socially withdrawn and unproductive in society (Schonfield, 1982). Certain physical or behavioral characteristics of elderly clients can affect the attitudes of nursing personnel who provide their care (Elliott & Hyberton, 1982).

Elderly clients may also respond behaviorally to the attitudes and behaviors of nurses. The elderly may be forced into patterns of behavior by the behavior of nurses toward them (White, 1977). According to this author, the elderly client may lack the strength or will to resist the patterning and expectations put on them by persons in their environment.

The elderly are the most stereotyped of any age group (Gioiella & Bevil, 1985). These authors state that beliefs influence attitudes which influence feelings, and that negative presentation of the elderly in literature, on television, and in jobs all contribute to negative beliefs and attitudes toward the elderly.

There have been many studies by social scientists on attitudes toward aging and the aged. Many have revealed negative attitudes toward the aged (Steffl, 1984a). Authors such as Burnside (1988), Dolinsky (1984), and Elliott and Hyberton (1982) state that negative attitudes and attributions on the part of nursing personnel result in less than adequate care for the elderly. Negative attributions may be internalized by an elderly person, and may subsequently influence his or her beliefs, behaviors, and self-concept (Cherry, 1981). The value a person places upon himself is a result of the social interplay which occurs between himself and those in his environment. Cooley (1922) coined the term, the "looking glass self". According to Cooley, when a person observes himself in a mirror, he does not see himself as merely a mechanical reflection. He imagines what effect his reflection would have upon another person and what would be the other's responses and judgment. As he imagines what this would be, he adopts it and so views himself as he imagines the other person would. The person's sense of self is derived from his definition of all his various roles, values, and goals which have been conveyed to him by others since birth (Cherry, 1981). Hospitalized elderly clients derive ideas about themselves according to what they "read" into the behaviors of the nurse, either directly or indirectly (through policies and rules). For example, raising the siderails of all older clients because

of their age rather than on the individual's ability fosters dependent behaviors and threatens the clients' self-esteem. This has serious implications for nursing practice since the achievement of independent performance of functional living skills is greatly influenced by self-esteem.

According to Gunter (1983) and Burnside (1988), nurses need to become aware of the importance of their own behavior in the care of elderly clients, and that treating older clients with dignity and respect maintains or restores their self-esteem. Elderly clients, however, report that nurses' behaviours toward them indicate a lack of dignity and respect (McInnes, 1987).

Although there are several studies which investigate the quality of care the elderly receive, there has been very little attention given to the elderly client's perceptions of the quality of their care, particularly as it relates to dignity and respect.

This study was designed to determine whether elderly clients in an acute care hospital perceived they were treated with dignity and respect and whether some elderly clients were more likely than others to be treated with dignity and respect.

Problem Statement

The effectiveness and quality of nursing care administered to the elderly is greatly influenced by nurses' attitudes toward this group of people (Alford, 1982; Brower,

1981; Burnside, 1988; Hatton, 1977; Storlic, 1982; Wolk & Wolk, 1971). Recently, the elderly have begun to speak out on the quality of nursing care they receive. More specifically, the elderly report they are not treated with dignity and respect and are made to feel like second-class citizens (McInnes, 1987).

According to the Code of Ethics for Nursing (Canadian Nurses Association, 1985), a client's right to be treated in a dignified fashion must be reflected in the nurse's own behavior. The Code contains values concerned with the responsibility of the nurse's behavior to treat clients with dignity and respect. Two of these values are: (1) "A nurse is obliged to treat clients with respect for their individual needs and values" (Canadian Nurses Association, 1985, p. 4), and (2) "the nurse has an obligation to be guided by consideration for the dignity of clients" (Canadian Nurses Association, 1985, p. 7).

Although there are studies which examine the quality of nursing care the elderly receive, there has been very little attention given to the elderly clients' perceptions of the quality of their care, particularly as it relates to dignity and respect.

Purpose of the Study

The purpose of this study was to explore whether elderly clients in an acute care hospital perceived they were treated with dignity and respect and whether elderly

clients with a higher socioeconomic status were more likely than others to perceive they were treated with dignity and respect. Whether elderly clients perceived they were treated with dignity and respect was determined by eliciting verbal responses to items on a questionnaire.

The research questions the investigator proposed to answer were:

1. Do elderly clients in acute care hospitals perceive they were treated with dignity and respect?

2. Are elderly clients within a higher socioeconomic status more likely to perceive they were treated with dignity and respect than clients with a lower socioeconomic status?

The following section explains the theoretical framework used to guide the investigation.

Theoretical Framework

Symbolic interactionism was chosen to serve as the theoretical framework for this study. This theory is adaptable to investigating how we may develop attitudes about ourselves on the basis of attitudes of others towards us.

From the perspective of symbolic interactionism, social reality is seen to be constructed through a process of interaction between individuals (Blumer, 1969; Stryker, 1980). Through this interaction, individuals give meaning to objects and situations they encounter and experience.

These objects or situations have no inherent meaning for an individual since the meaning emanates from the way the object is defined by those with whom the individual interacts (Blumer, 1969; Meltzer, Petras, & Reynolds, 1977).

How we interact with others involves interpreting the meaning of the action of others and our own previous experience (Blumer, 1969). This interpreted meaning then acts as a basis for action that reflects our own intended meaning. Since interaction involves reciprocally influenced behavior, social interaction is considered to be the determiner or reactor of behavior, not merely a form of its expression (Blumer, 1969; Meltzer et al., 1977).

Charles H. Cooley (1922) and George Herbert Mead (1934) are two of the founders of the symbolic interactionist approach (Meltzer et al., 1977). They noted that a person's self-concept is a social phenomenon. It develops as a result of the variety of roles taken on by the person in social interaction. In this approach the individual is considered to be an active participant in a specific social situation or setting. During this process the individual defines and interprets a specific setting, in personal terms, because of interacting with others who are of significance to him verbally or symbolically (through dress, language, gestures and mannerisms). In this way, social meaning is attributed to the symbols and behaviors, and thus shared meanings of the situation or setting are derived

according to the meaning the situation has for each individual.

Symbolic interactionism involves three processes that culminate in specific meanings and therefore in cognitive or behavioral acts. First, the individual defines the social situation in terms of how it operates and what it means for him/her (Blumer, 1969; Thomas, 1934). Second, according to Cooley (1922), individuals observe and interact with others in order to analyze and arrive at a definition of the "self". In this way, we as individuals consider how others see us and how others evaluate what they see in us. As a result of this evaluation and interpretation, which is ongoing and continuous, we arrive at a view of ourselves and the situation, and behave accordingly. The third process involves what Goffman (1959) calls "the presentation of self". Individuals define the situation and setting and then decide how they will present themselves to others in terms of dress, manner, and content of interaction and behaviors. According to this author, the type of dress, speech, and behavior pattern is selected in order to present a self which is appropriate to the specific situation.

Symbolic interactionism represents an examination or analysis of a specific social process or situation that occurs in everyday life. The emphasis, then, is on social interaction as a process, and the various meanings and interpretations each participant brings to that interaction.

Its main concern is with how each individual interprets and assigns meaning to a specific situation, behavior, or event.

This meaning emphasizes the importance of feedback from significant others in the development of "the self". According to Jourard (1974), people's views of themselves are strongly influenced by others' definition of them; we continually instruct others as to how they should perceive us. This author points out that this vulnerability to another's influence may be a liability or an asset. If others project a negative attribute on another person, this attribute may be internalized by the person, making the vulnerability a definite liability. The vulnerability may be an asset, however, if a significant other projects an attribute of worthiness and strength to a person. In this way, the person's self-concept is maintained or enhanced.

The term "self-concept" refers to the attitude and evaluation an individual has concerning himself or the way the self is evaluated. In fact, we may develop attitudes about ourselves on the basis of attitudes toward us in given settings. According to Cooley (1922) and Mead (1934), an individual's self-concept is a social phenomenon. It develops as a result of the variety of roles taken on by the individual in social interaction. That is, the self reflects the responses of others toward the individual, as perceived by the individual's own ability in understanding how others see him or her.

According to Mead (1934), one's self-concept is never gained nor maintained once and for all and is quite open to change and development over time. It is highly interrelated with other people's perception of us. Proponents of a symbolic interactionist view maintain that aging outcomes reflect the reciprocal relationship between the individual and his or her social environment; the individual simultaneously externalizes his own being into the social world and internalizes it as an objective reality (Cherry, 1981). According to this author, feelings of self-worth and life satisfaction are maximized when there is congruence between the individual's self-concept, his interpretation of the behavior and the behavior of others in relation to him.

In relation to the hospital setting, the elderly client's self-concept during a critical period may be maintained or enhanced if his basic human needs for accomplishment (mastery), love, belongingness and dependence, and respect of self by self and others (self-esteem) are met. These needs are largely met through social interaction by the client developing those coping behaviors capable of maintaining need satisfaction and goal achievement. That is to say, the elderly client's coping behaviors are influenced by the meanings he/she attaches to the behavior of nurses toward him or her (Blumer, 1969; Jourard, 1974). When nurses introduce the client to their surroundings, provide them with information, address them

appropriately, insure their need for privacy, explain procedures before they are done, and provide an opportunity for clients to express their fears and concerns, they are treating clients with dignity and respect. The meaning those nursing actions have for elderly clients maintain or enhance their self-concept. Conversely, the elderly client's self-concept will be threatened during a critical period if nursing interventions do not assist him to develop suitable coping behaviors to meet his needs for mastery, love, belonginess and dependence, and self-esteem. Meanings are modified and dealt with through an interpretative process used by persons in dealing with those things they encounter (Blumer, 1969).

The elderly client's self-concept is not diminished and may be enhanced if there is congruence between what the clients believe about themselves, and the interpretation of the action of others in relation to them. Through a process of interpretation and interaction, elderly clients' perceptions and actions may be influenced by how care-givers (registered nurses) view elderly people. If the actions and behaviors of the care-givers are incongruent with elderly client's positive perceptions of themselves, the self-concept is undermined (Kuypers & Bengston, 1973). These authors argue that the elderly internalize these external evaluations and begin to behave as expected (the self-fulfilling prophecy). Davis (1968) asserts that older

people tend to adopt whatever role is expected of them. According to Cherry (1981), negative attributions may be internalized by an elderly person, and may subsequently influence her beliefs, behaviors, and self-concept.

Given this framework, the focus of this study was to explore whether elderly clients (in an acute care setting) perceived the actions and behaviors of nurses towards them were congruent with their perceptions of themselves (their self-concept). This information was obtained by determining (using a structured interview format) whether elderly clients who received nursing care in an acute care setting perceived they were treated with dignity and respect.

Definition of Terms

Attitudes: absolute inclinations or mental readiness which consistently exert influence on evaluative responses that are directed toward some person, group, or subjects (Zimbardo & Ebbesen, 1969).

Dignity: being worthy of honor or respect (Allen, 1984).

Elderly: a person 65 years of age and above.

Perception: thoughts, feelings and attitudes of individuals about objects or events as related verbally.

Respect: deferential esteem felt or shown towards person; avoid interfering with or harming, treat with consideration; refrain from offending person or feelings (Allen, 1984).

Socioeconomic status: defined in terms of a standard sociological paradigm consisting of three components; education, occupation, and income (George & Bearon, 1980). The level of education was selected as an indication of socioeconomic status for this study since education is considered to be a determinant of socioeconomic status throughout life. For the purpose of this study, those with a secondary level of education will be regarded as having a higher socioeconomic status and those with an elementary level of education a lower socioeconomic status.

Assumptions

1. Individuals (clients and nurses) act purposefully and these actions are influenced by the individual's interpretation of the setting, situation or behavior of individuals in the setting or situation.

2. The selection of elderly clients for the study was dependent upon their activities and willingness to communicate perceptions verbally.

3. Attitudes of nurses affect their behaviors, and their behavior influences the nursing care they administer to the elderly.

4. The questions that have been selected from the Medicus Quality Assurance tool are those that will elicit information on whether identified aspects of nursing care were perceived by the client to meet his/her needs for dignity and respect.

Limitations

No methodology existed which measured the client's perception of nursing care with complete adequacy. Moreover, any relationship between the attitudes of nurses and the quality of nursing care in this study can only be inferred, since the attitude of nurses in this sample was not observed or measured. With convenience sampling, and the omission of those clients who were not alert and oriented, the available subjects might not be typical of the population with regard to the variables being measured. Generalizability of the findings may be limited.

Summary

This introductory chapter described the nursing context of the research problem and explained the rationale and purpose of the study. The theoretical framework, the research questions, the assumptions and limitations of the study were addressed. The next chapter provides a review of literature pertinent to the investigation.

CHAPTER 2

Review of Selected Literature

This chapter reviews pertinent theoretical perspectives and research studies. The literature reviewed was selected on the basis of a symbolic interactionist view of how elderly clients view their nursing care, and their care-givers (registered nurses) as reciprocally influencing elements of their hospital experience. From this perspective, the review of the literature is organized into seven main parts: (1) growth of the elderly population, (2) basic human needs and the elderly population, (3) the hospitalized elderly, (4) aging and self-esteem, (5) ethical considerations in the care of the elderly client, (6) attitudes of nurses towards the elderly, and (7) the older person's perception of their nursing care.

Growth of the Elderly Population

The number of people over 65 years of age is steadily increasing. It was initially projected that in this country by year 2001, this group would comprise about 11% of the population (Statistics Canada, 1980). But with recent improvements in survival rates in the older population and a major decrease in birth rate, the percentage of people over 65 has been revised upwards (Stone & Fletcher, 1986). Quoting Statistics Canada data, these analysts project that

by year 2001, 14% of the population will be over 65 years and by year 2031 this figure will increase to approximately 25%. These findings will be reflected in an increased number of people over the age of 65 requiring nursing services. The distribution of the population indicates that registered nurses, the single largest group of health care workers in Canada, are encountering the elderly more frequently in their practice. They provide nursing care to the elderly in long term and chronic care institutions, in the community, and in acute care hospitals. In British Columbia, for example, the number of admissions to acute and rehabilitation hospitals and hospital days used, increase dramatically after age 55. In 1982-83, the number of admissions per thousand people age 70-74 was almost four- and one-half times larger than that for the aged 55-59 group; among those age 85 and over, it was more than five times larger (Gutman et al., 1986). While hospital usage in British Columbia generally fell between 1971 and 1982-83 as a result of efforts to reduce hospital bed capacity, this overall decline did not occur among the elderly. Gutman points out that admission rates per capita during this period increased for all age groups of men over the age of 65 and women over the age of 70. Although the public perception is that the elderly make great demands on the hospital system, only 20% of those over 65 are admitted to hospital in any given year. Out of this group, however, 5%

consume 60% of the hospital days; of that high-use group, about half are in their last year of life or are waiting for a bed in a nursing home (Silversides, 1987).

To clarify health policy, the federal government defined five levels of institutional care: residential, extended care, chronic hospital, rehabilitation, and acute hospital; the first three are considered long term care. In British Columbia, five levels of long term care are defined as Personal Care, Intermediate Care I, Intermediate Care II, Intermediate Care III, and Extended Care (Forbes, Jackson, & Kraus, 1987). Long term care services and programs are required by those individuals who have some degree of functional impairment because of physical and/or mental frailty or disability (Mantle, 1988a). According to Mantle, the development of community support services has enabled the elderly to live within the community for longer periods of time. Elderly residents are now much older before they enter a facility and have much greater degrees of physical and mental disability.

Gutman et al. (1986) point out that while level of care cannot be predicted by age alone, the probability that some level of service will be required increases dramatically with age. In 1984, 55% of the population aged 85 and over were receiving long term care services. This figure compares with 21% in the age group 75-84 and only 6% in the age group 65-74. The proportion of persons receiving

continuing care in facilities also rises with increasing age. Of those aged 85 and over in care, about two-thirds were in facilities. While approximately 80% of people over the age of 65 in Canada (Health and Welfare Canada, 1982) are capable of living independently and caring for themselves (in spite of the fact that 75% of older people suffer from at least one chronic health problem), there is a relationship between being older and requiring more care and being in a facility.

Basic Human Needs and the Elderly Population

In the UBC Model for Nursing (Campbell, 1987), a behavioral system model, the individual is assumed to have nine basic human needs which persist throughout life. The nine needs include the need for mastery, love, belongingness, and dependence; respect of self by self and others; collection and removal of accumulated wastes; intake of food and fluid; nourishment; safety and security; balance between production and utilization of energy; intake of oxygen; and stimulation of the senses. The individual constantly strives to satisfy each basic human need by using a range of innate and acquired coping behaviors. Behavior and personality characteristics are influenced by the suitability of the coping behaviors he uses and the ways his basic human needs are met.

Basic human needs persist throughout life. They are fundamental requirements for survival and growth of the behavioral system (Campbell, 1987).

Conceptualizing a hierarchical framework of basic human needs, Maslow (1968) viewed growth as "a continued, more or less steady upward or forward development" (p. 33). Beginning at the lower end (the most basic part) of the hierarchy are physiologic needs that are important for survival. These needs include food, water, air, sleep, and sex. Next are the needs for safety, which include security, protection, freedom from anxiety, and some degree of routine and predictability in daily living. When physiologic and safety needs have been met, belonging and love in a caring relationship assumes importance. Meeting this need is an essential prerequisite to meeting esteem needs, which include reputation, status, prestige, and a feeling of self-esteem built on individual self-worth. When physiologic and safety needs, belonging, love, and esteem needs are met in satisfactory succession, the person can focus on tasks for self-actualization. Maslow believed that in the process of growth, a person has to satisfy basic needs before the person can be motivated toward self actualization (becoming all the person is capable of becoming).

Steffl (1984b) points out there are many misconceptions about where older people are expending their energies. We may expect old people to be self-actualizing when, in fact, their self-esteem is being threatened and they are devoting all their energy to ensuring that their physiological needs are met.

According to the UBC Model of Nursing basic human needs are not hierarchial in structure; all nine needs must be met regularly in order to achieve behavioral system stability and one human need does not take precedence over another human need (Campbell, 1987).

Erich Fromm (1955) describes identity, rootedness, relatedness, transcendence, and a frame of reference as universal basic human needs. He states that everyone has a need to have an identity, have a place in time and space (rerooting is difficult for older people), and our society depends on relatedness to someone or something. Man, according to Fromm, is the only animal that has an awareness of his own finiteness and speculates about it, has a need to leave something behind, and needs a set of beliefs (religious or non religious) to fall back on.

Three basic social-psychological needs of elderly individuals described by Bengston (1978) are identity, connectedness, and effectence. The most important part of identity is who one is (surname, title, role). Connectedness is defined in terms of the social situation in which we all live and die. Effectence means having some sort of influence on your environment and being able to effect change (Bengston, 1978).

Communication and interaction with other human beings are basic human needs which are vital for the elderly person maintaining a "lifeline". Interaction with other people

becomes more difficult in old age when family and friends die (Burnside, 1988; Ebersole & Hess, 1985).

Personal space, territorial domain, and spatial arrangements are important elements in basic human needs (Gioiella & Bevil, 1985; Pastalan, 1970). Personal space refers to the distance individuals maintain between themselves and others. It may be viewed as a bubble surrounding the person - a buffer zone between oneself and the environment. That is, they need individually determined spatial distances for conversation and social interaction.

Territoriality is defined as a delimited space used by individuals or groups, involves psychological identification with the area, and is symbolized by attitudes of possessiveness and arrangement of objects (Pastalan, 1970). This author explains that individual territory is physical or geographical and is visible in nature, whereas personal space is more psychological because it is carried around with the individual and is not visible. A person will identify the boundaries of his territory with a variety of environmental props, both stationary and mobile, so they can be seen by others. The boundaries of personal space are invisible though they may be inferred from facial expressions, body movements, gestures, pitch or tone of one's voice and visual contact.

When hospitalized (Stillman, 1978), individuals usually experience a loss of privacy and control over their bodies

and surrounding area. They are denied their own familiar territory. Possession of territory helps meet a need for security and identity, while loss of it can interfere with psychological homeostasis.

The Hospitalized Elderly

The elderly are a heterogeneous group, with wide differences in their physical and psychosocial status. Yet, the tendency is to deal with all persons over the age of 65 as though they are all developmentally the same (Burnside, 1988; Ebersole & Hess, 1985).

As a group, older persons are more likely to experience multiple chronic and disabling conditions. With these chronic problems, the risk is for further decline in function and acute exacerbation of the disease (Bossenmaier, 1982; Gioiella & Bevil, 1985).

The normal age-related physiological and psychosocial changes that occur place the older person at risk during hospitalization. For example, alterations in vision, hearing, and other sensory modalities can affect cognitive function (Chodil & Williams, 1970; Worrell, 1977). According to these authors the individual maintains contact with the environment and experiences reality through reception and perception of sensory interaction. Use of color, light, texture, attention to activity and noise, furnishings, placement of equipment, mobility aids and care giver routine can promote or impede recovery. When the

hospital does not meet the elderly person's need for meaningful environmental interaction, acute confusion may result. The presence of confusion predisposes the elderly client to a possibility for falls, incontinence, sleep disturbances, mobility and skin problems, and dependency increases (Burnside, 1988; Ebersole & Hess, 1985; Worrell, 1977).

The circumstances requiring hospitalization may mean a loss of health, functional ability, independence, or potential loss of self through death. Anxiety and depression are common responses to hospitalization and older clients who are mentally alert can be expected to react with heightened levels of these emotions (Gioiella & Bevil, 1985; Rossman, 1979).

Additional characteristics that put the acutely ill, hospitalized aged at risk are diminished physiological reserves and decreased capacity to adapt to unfamiliar surroundings (Bossenmaier, 1982; Rowe, 1985). The daily coping behaviors required to deal with multiple chronic and acute health problems, decreasing independence, impending life-style changes, all in the presence of declining resources, are seriously threatened when an unpredictable event such as hospitalization is sudden and unplanned (Burnside, 1988; Gioiella & Bevil, 1985).

Relocating from a familiar, safe living environment to an unfamiliar hospital environment that requires interacting

with unknown persons in the absence of reliable support systems and familiar routines contributes to the older person's vulnerability (Ebersole & Hess, 1985). This situation predisposes the older person to experience helplessness, dependency, and loss of control. Even when the older adult is capable of utilizing suitable coping behaviors to meet some of their basic human needs, staff members may believe it is faster or easier to do things for them, thus reinforcing the older person's dependent position. These losses weaken the older client's feelings of self-confidence, mastery, and sense of self-esteem (Gioiella & Bevil, 1985).

Aging and Self-Esteem

According to the UBC Model for Nursing (Campbell, 1987), man has basic human needs for safety and security, collection and removal of accumulated wastes, balance between production and utilization of energy, intake of oxygen, intake of food and fluid, stimulation of the senses, for love, belongingness and dependence, mastery, and for respect of self by self and others (self-esteem).

An essential factor for successful aging is to meet the need for self-esteem or a positive self-concept (Burnside, 1988; Gioiella & Bevil, 1985). These authors state that to meet the need for self-esteem, the older individual must be aware of his own identity, must have control over his own life, must have a sense of self-worth, and must have

affiliations with others. Butler and Lewis (1977) argue that for individuals with low self-esteem, life becomes meaningless and feelings of hopelessness and helplessnes pervade their lives.

Hospitalization emphasizes the older person's physical deterioration and loss of health, mobility, and independence. This loss of independence weakens the older person's feelings of self-confidence and sense of self-esteem (Burnside, 1988; Gioiella & Bevil, 1985).

The older person's self-esteem may be further damaged by the depersonalization that occurs with hospitalization. Upon admission clients are dressed in hospital gowns and their personal possessions and jewelry are removed. They are deprived of privacy to carry out the most basic bodily functions or maintain intimate or family relationships (Kemp, 1978).

Maslow (1970) indicated that control is a critical variable influencing self-esteem. This control includes making decisions about one's self. Reid, Hass, and Hawkins (1977) reported a positive relationship between low self-control and negative self-concept and described those who had a negative self-concept as tending to have less life satisfaction. Bower and Bevis (1979) observed that health promotion and self-care promotion are major generative functions that must be performed by the elderly in order for their self-esteem needs to be met. Anger, indecisiveness,

and depression are signs that these self-esteem needs remain unfulfilled.

According to Ebersole and Hess (1985), the critical factor in the older person's response is perception. The impact of an event on one's self-esteem and sense of capability will affect the degree of response more than the magnitude of the event. These authors have identified productivity and problem-solving ability as essential to the maintenance of self-esteem in the elderly and have suggested that the nurse's role is to assist in development of these coping abilities.

According to the UBC Model for Nursing (Campbell, 1987), nursing interventions focus on coping behaviors related to goal achievement. Interventions are aimed at discouraging or eliminating coping behaviors associated with lack of goal achievement and potential lack of goal achievement, and encouraging and developing those behaviors capable of maintaining and promoting goal achievement. Change with respect to a client's coping behaviors can be effected by reduction of negative forces, maintenance and strengthening of positive forces, and fostering of the development of abilities.

To practice nursing in such a way as to assist elderly clients to develop and use coping behaviors to meet the need for respect of self by self and others, and attain the goal of self-esteem is an ethical duty.

Ethical Considerations in the Nursing Care of the Elderly Client

As viewed in the UBC Model for Nursing (Campbell, 1987), nursing's unique function is to nurture individuals experiencing critical periods so that they may develop and use a range of coping behaviors that will allow them to satisfy their basic human needs and to reach optimal health. Nursing's role in nurturing individuals is to foster, protect, sustain, and teach. According to the Canadian Nurses Association (1985) nursing practice can be defined generally as a "dynamic, caring, helping relationship in which the nurse assists the client to achieve and maintain optimal health" (p. 6). By entering the profession, the nurse is committed to its professional ethics and assumes a professional commitment to the health and well-being of clients. As such, nursing encompasses moral activities.

Ethics, a branch of philosophy, promotes moral conduct based on principles of behavior that promote the goodness of the human being (Bahr, 1987). This dignity and respect to be afforded the individual regardless of age brings a focus of equality for that individual. This equality, based on the value of the human being as a worthwhile individual, identifies a value system needed to preserve the dignity of the person, young or old. According to the Canadian Nurses' Association Code of Ethics for Nursing (1985), "a client's right to be treated in a dignified fashion must be reflected

in the nurse's own behavior towards the client and in attempts to influence the actions of other members of the health care team" (p. 3).

The way in which nurses are involved in situations which give rise to ethical conflict is frequently related to institutional policy, the place of the nurse in the organizational hierarchy and the professional division of labor. According to Storch (1988), the uniqueness of nursing's ethical dilemmas can be a function of being there, having multiple obligations, and experiencing the daily ceaseless dilemmas of care.

Because nurses are generally the health care professionals who are with the client on a more constant basis than other health care providers, they are present to witness the client's loss of autonomy and submission to health care ministrations (Storch, 1988). When these ministrations are not in the client's interest or contrary to the client's wishes, the nurse is present to act for the client or remain a silent observer of a wrong. Because obedience and silence are no longer considered appropriate behaviors for the nurse (Coburn, 1981), many nurses experience conflict in fulfilling their ethical responsibilities. And because the nurse is present, the ethical and moral dilemmas of practice become even more serious when the nurse is excluded from the process of decision-making on matters of treatment. This exclusion

places nurses in a difficult position when they must implement the decisions even when they disagree with them.

A second reality of nursing practice related to nursing ethics is that nurses have multiple obligations (Storch, 1988). Nurses have professional obligations to clients, to families, to physicians, to colleagues, and to institutions where they are employed. Early nursing education cautioned against questioning the physician's decisions. Since the 1970s, however, the priority of the nurse's obligation to the client has been clearly stated in Codes of Ethics and Standards for Nursing Care (Canadian Nurses Association, 1985; Registered Nurses Association of British Columbia, 1984).

According to Storch (1988), the problem of multiple obligations for nurses who work in institutional settings continues to be a source of role conflict for nurses. Citing several authors, Storch (1988) points out that the work place can influence the moral judgment of nurses; "loyalty to the organization, physician, and colleagues competes with loyalty to patient and family" (p. 213).

Nurses experience a range and variety of ethical dilemmas every day (Storch, 1988). There are issues which involve life and death decisions and the less spectacular issues such as breaches of client confidentiality and invasion of privacy. And there are the ethics of caring by which nurses try to determine the needs of their clients for

whom they care. These daily obligations demand an ethical responsiveness on the part of nurses with a professional responsibility to act in the client's best interest.

Curtin and Flaherty (1982) state that it is not likely that nurses will deliberately transgress the rights of clients, but:

> It is in our ordinary day to day contact with patients or clients that we are most likely to fail to respect them as human beings. We are too busy or too caught up in the "important" technicalities to take the time to discover and respect the humanity of each individual. (p. 15)

Commenting on the central ethical issues for nurses, Storch (1988) points out that maintaining the patients' or clients' interest as top priority means that nurses must recognize and cope with "being a patient's advocate; dealing with unethical disagreement, incompetence, or unprofessional practice; and being a competent practitioner" (p. 214). Advocating the interests of the client includes assistance in achieving access to quality health care. For example, by providing information to clients, the nurse enables them to satisfy their rights to health care. Although the nurse has always functioned as the client's advocate to some degree, the priority of client advocacy has sometimes been in conflict with advocacy for the institution or physician (Storch, 1988). This author points out that some degree of

conflict is inevitable when dealing with other groups in matters of health care. Nurses are accountable, however, for the well-being of patients and they must take action when treatment orders seem inappropriate. Moreover, they must ascertain the facts of the situation and use institutional reporting channels when dealing with matters of clinical incompetence and professional misconduct.

An obligation of equal importance is that nurses maintain their own competence as practitioners. Storch (1988) points out that nurses must take advantage of formal and informal opportunities for continuing education, read and study professional journals, recognize their own limitations, and strive to provide a high quality of patient care.

Recognizing one's professional and ethical responsibilities for client advocacy, dealing with conflict, and ensuring competence can make a significant difference in the lives of clients which may cover the whole range of human life from birth to death.

Attitudes of Nurses toward the Elderly

Studies show that nurses least prefer working with the elderly and that nurses who hold negative attitudes toward them will engage in behaviors which may not be therapeutic or may be detrimental to the best interest of the elderly client (Brower, 1981; Campbell, 1971; Lueckenotte, 1987; Penner, Ludenia, & Mead, 1984). Goebel (1984) states that

attitudes are a potential influence on interpersonal behaviors in situations where clients of all ages are dependent on caretakers. Negative attitudes among nurses, therefore, have serious implications for this rapidly increasing client population.

Although interest and concern for the elderly has been growing in recent years, many elderly clients in health care facilities continue to receive inadequate poor quality care which is not individualized and is depersonalized (Campbell, 1971; Health and Welfare Canada, 1982; Podnieks, 1983). According to Ebersole and Hess (1985), the myths dangerous to the older person in our society are those that perpetuate the idea that the aged are dependent and the young are independent. These authors say that attitudes of nurses toward aging and the elderly is one of the factors that contributes to an inferior quality of nursing care. Stanley and Burggraf (1986) state that this is significant because of the dependency that is created by the multiple chronic conditions affecting the elderly.

Several studies have investigated attitudes of nurses towards the elderly. Some studies reveal that nurses' attitudes towards the elderly are characterized by stereotyping, negativism, and defeatism (Campbell, 1971; Nelson, 1973). Others (Kogan, 1979; Schonfield, 1982) point out that the elderly are generally perceived by younger people as physically and mentally on the decline, socially

withdrawn and unproductive in society. These stereotypes, they say, can adversely influence interactions with the elderly and influence the care nurses provide. Nelson (1973) reported on a study done by Stockwell to investigate if nursing care differed between "most liked" and "least liked" clients. Stockwell found that elderly clients were most likely to fit the characteristics of clients which nurses "least liked" and were more likely to receive negative responses from nurses. Negative responses were reflected by the amount of time taken to answer call bells, amount of time the nurse spent in verbal communication with clients, and the number of injections nurses were willing to give clients to relieve pain.

Not all studies on nurses' attitudes towards the elderly indicate negative attitudes. Taylor and Harned (1978) found that attitudes of registered nurses were all positive or neutral and that nurses who worked in acute care hospitals had more positive attitudes than their counterpart in long term care. Brower (1981) reported that nurses employed in nursing homes had significantly more negative attitudes toward the elderly in general than did nurses who worked as visiting nurses or in a hospital. This author found that the major reason for more negative attitudes among the nursing home nurses was at least in part due to caring for a number of elderly clients who have multiple physical and emotional problems. A study by Wolk and Wolk

(1971) found that younger nurses had more negative attitudes toward the elderly than did older nurses. These authors believe it is because younger nurses had less direct experience with elderly clients. Attitudinal studies by Futrell and Jones (1977) found that older, better educated and more experienced registered nurses tended to have the most positive attitudes.

Other studies suggest that factors associated with individual clients, other than age, are more powerful determinants of the attitude and behavior of nurses. For exampe, nurses prefer clients who are neat, appreciative, conforming, socially active and communicative and do not value clients who place extra demands on the system by being uncooperative, disruptive, or soiling the environment (Penner et al., 1984; White, 1977). These qualities are associated with lower self-care ability rather than age or diagnosis. According to a study by Brown (1969), nurses were observed to give extra care to dying clients who are "socially valued", who occupy high status, or who are highly prized by virtue of age, relationship to another, or productivity. Henretta and Campbell (1976) reported that the higher the individual's social class, the greater the likelihood of maintaining status for a longer time; they have resources that give them power in social relationships, thereby enabling them to remain independent. White (1977) found that clients who scored lower with

respect to activities of daily living and social participation received from nursing fewer individualizing behaviors such as screening for privacy during care, conversation, and explanations of what was going on during process of care. According to Elliott and Hyberton (1982), clients who elicit favorable reactions in a nursing staff are more apt to receive adequate attention to their needs than clients who exhibit disturbing and troublesome behavior. Those clients, she states, who elicit unfavorable reactions are not as likely to receive the same level of nursing care.

Two authors (Grouse, 1982; Natkins, 1982) address derogatory descriptors used toward the elderly. They both emphasize the importance of a person's name and portray instances which clearly denigrate clients. Grouse discusses the legitimization of derogatory terms such as "crock", "turkey", "gomer", "dirtball", and "spos". Burnside (1988) succinctly points out that nurses who call clients by their first name without asking what they want to be called, or call them "granny" or "gramps", "dearie" or "honey" are threatening the clients' dignity and self respect.

Dolinsky (1984) points out that nurses infantalize the elderly by treating them as children who are incapable of caring for themselves. Gresham (1976) describes various ways that demonstrate how older people are treated in nursing homes, acute care hospitals, and extended care

facilities. Some of these include addressing the elderly by their first name whether or not they request it, patting the elderly on the head, patronizing the aged, and not including the aged in decisions about their own care. Butler (1980) states that addressing the elderly by their first or "pet" names should be avoided as that implies loss of dignity and infantalization.

The Elderly's Perception of their Nursing Care

There have been few studies which look at how the elderly perceive their nursing care. Although a limited number of studies look at patient satisfaction, their purpose is to discover how satisfied elderly clients were with a particular facility (Forgan Morle, 1984). One study (Elbeck, 1986) which did investigate the ways in which clients describe and evaluate nursing practice does not identify the age group of the client population. There are, however, reports in the media of the elderly's dissatisfaction with the quality of care they receive. Panel members from a Consumer Advisory Panel on Seniors Health Issues (McInnes, 1987) report that the elderly are made to feel like second-class clients in hospitals; they are "treated like infants, or automatically assumed to have some form of Alzheimer's disease". The report states that many health care professionals are observed to call elderly clients "dear" or use their first names on first meeting. As well as being treated like children, they are not

informed about their condition or treatment. Other incidents, the report states, include nurses referring to clients as "bed-blockers" or "GOMERS", which stands for "get out of my emergency room", within hearing distance of the client. This behavior, the elderly report, deprives them of their dignity and self-respect.

Since attitude is one of the elements that affects the performance of the registered nurse, it is assumed that this performance is reflected in the kind of care the elderly client receives; one area of nursing care which is questioned by this researcher is whether the elderly client is treated with dignity and respect.

In conclusion, this literature review indicates the following: an increase in the elderly population resulting in an increased need for nursing services; attitudes nurses hold about the aged influence the quality of services they provide; and, there is a scarcity of studies which explore the elderly's perception of their nursing care, particularly as it relates to whether they were treated with dignity and respect.

Summary

This chapter reviewed the literature in relation to the elderly's increased needs for nursing care due to demographic changes, attitudes of nurses toward the elderly, the implications of these attitudes for the elderly and briefly (due to limited studies), and the elderly's

perception of their nursing care particularly as it relates to their need to be treated with dignity and respect. The next chapter describes the process of this investigation to address the research question.

CHAPTER 3

Methodology

Research Design

This study used a descriptive and correlational research design. According to Polit and Hungler (1983), descriptive research is designed to summarize the status of some phenomenon of interest as it presently is thought to exist. Its main objective is the portrayal of the characteristics of persons, situations or groups and the frequency with which certain phenomenon occur. Correlational studies are research investigations designed to examine the relationship among variables. Descriptive correlational studies are less concerned with determining cause-and-effect relationships than with a description of how one phenomenon is related to another (Weldon, 1986).

A structured interview with "fixed alternative" questions was utilized to obtain the data. This type of questioning offers respondents a number of alternative replies; the subjects were asked to choose the one that most closely approximated the "right" answer. The number of responses to each alternative was tabulated and analyzed in order to obtain some understanding of what the sample as a whole thought about each question.

Sample

The required sample consisted of 62 subjects who were 65 years old or over.

This research study utilized an accidental sampling technique. This technique entails the use of the most readily available persons for use as subjects in the study (Polit & Hungler, 1983). For example, all subjects who met the study criteria and were being discharged from hospital during the study period were included in the sample.

The criteria for inclusion as subjects of the sample were: 65 years of age and over; hospitalized for no less than 5 days in a Medical or Surgical Unit; able to respond verbally in English; alert and oriented to time, place, and person during their hospitalization; and interviewed within 3 days after they left hospital.

Instrument

A review of the literature to discover an existing tool was not successful in finding an instrument useful for the purpose of this study. The literature review, however, did uncover a tool that had been developed to monitor the quality of nursing care (Hegyvary & Haussmann, 1975). The tool (Medicus Quality Assurance Tool), a self-reporting questionnaire contains several items dealing with the provision of nursing care demonstrating regard for dignity and respect. The selection of items from the Medicus Quality Assurance Tool related to dignity and respect was

determined by defining and developing an operational definition of the terms. Information to operationalize the terms "dignity and respect", was obtained from items in the master indicator list of the Medicus Quality Assurance Tool and review of selected literature (Chapter 2). These items were: orienting the client to the facility, providing clients with privacy, seeking their permission before performing procedures, providing them with information, addressing them by their proper name unless otherwise requested, and providing an opportunity for them to discuss their concerns. A copy of selected items from the Medicus Quality Assurance Tool is found in Appendix D.

Since only part of the tool was relevant to this study it was necessary to determine what effect using only selected portions would have on reliability and validity. It was found that using selected portions of the Quality Assurance Tool would not affect reliability or validity since each item, although interrelated with others, has been tested independently (Sue Hegyvary, personal communication, 1988).

In order to determine if there is a relationship between certain client characteristics and whether clients perceived they were treated with dignity and respect, other data such as: age of the client, sex (male or female), number of days spent in hospital, type of unit (medical or surgical), and highest level of education obtained (to determine socioeconomic status) were elicited.

Socioeconomic status is defined in terms of a standard sociological paradigm consisting of three components; education, occupation, and income (George & Bearon, 1980). The level of education was selected as an indication of socioeconomic status for this study, since education is considered to be a determinant of socioeconomic status throughout life. Occupation and income, according to George and Bearon (1980), may not be significant for older people since a majority of them are retired and some occupational benefits are lost. Moreover, retirement drastically reduces the earnings of many older people.

Data Collection Procedure

The investigator contacted the Directors of Nursing of two large metropolitan teaching hospitals. These two acute care hospitals (A and B) were selected because of the need for samples of subjects who had nursing care provided primarily by registered nurses.

A plan to seek consent from the prospective subjects before they left hospital was developed by meeting with the head nurses of five medical and five surgical units from both hospitals. Their support was enlisted in informing the investigator of subjects who met the study criteria and were being discharged from hospital.

Before leaving the hospital, the prospective subject was approached by the investigator and provided with a verbal and written explanation of the study. Those subjects

who consented were provided with a form to sign indicating their willingness to participate. Arrangements were made by telephone to interview the consenting subjects at home within three days of discharge from hospital. All subjects who participated were interviewed within a five-week period.

Human Rights Protection

Approval for this study was provided by the UBC Behavioral Sciences Screening Committee for Research. Subjects in the study were provided with information (see Appendix A) regarding details of the study with respect to why the study was being conducted, where, how much of their time was required, and that participation was voluntary. All subjects selected for the study were informed that signing the consent form (see Appendix B) was taken as a consent to participate in the study. They were informed that refusal to take part or withdrawal from the study would not jeopardize any future treatment, medical care, or hospitalization. No personal information that could result in identification of the person and their data was requested. Data would be shared only with the two professors on the Thesis Committee. Confidentiality was emphasized and the subjects were assured that all data would be destroyed after the investigator had completed her Master's Thesis.

Data Analysis

The process of analysis included coding the interview responses and tabulating the data. Descriptive statistics

were used to analyze the characteristics of the sample and the responses to the questionnaire. In addition, P-values from the Chi-square test are given for the first three (3) items on the questionnaire. The remainder of the items (questions 4-10) are analyzed to determine the frequency with which selected responses occurred. Because of the nature of the responses and small sample, these questions were not amenable to significance testing.

Summary

This chapter discussed the processes undertaken to apply quantitative methods to determine if elderly clients in an acute care hospital perceived they were treated with dignity and respect and whether this was related to their socioeconomic status. A discussion on the selection of the sample, instrument, and procedure for collecting and analyzing the data was included. Attention to the protection of human rights was provided.

Discussion and significance of findings follow in subsequent chapters.

CHAPTER FOUR

Presentation and Discussion of Results

Introduction

The results of this study are organized into the following areas: characteristics of the sample, findings related to research purposes, and discussion of the results.

Characteristics of the Sample

The sample of 62 subjects was obtained from medical and surgical units of 2 university affiliated teaching hospitals located in Vancouver, BC. Each hospital contains approximately 1,000 beds and is a major referral center. Data were analysed according to: (1) sex, (2) length of stay [LOS], (3) age, (4) type of unit (medical or surgical), and (5) level of education (measure of socioeconomic status).

Sex

The sample of 62 subjects was composed of 39 males and 23 females.

Length of Stay (LOS)

The subjects were in hospital from a minimum of 5 to a maximum of 66 days with a mean stay of 17 days and a median stay of 14 days. Using the median to subdivide the group with respect to LOS, 35 subjects were in the "short stay" (5-14 days) and 27 in the "long stay" group (15+ days).

Age

The subjects ranged in age from 65 to 91 years with a mean of 76 years and a mode of 76 years; 25 of the subjects were from 65 to 74 years of age (younger old) and 37 were 75 years of age and over (older old).

Type of Unit

The data indicate that 34 subjects were from medical units and 28 from surgical units.

Level of Education

The level of education attained (used as a measure of socioeconomic status) showed that 27 of the subjects had an elementary school education, 27 had a high school education (secondary education), and 8 had a post-secondary education ranging from 2 years of college or university to completion of doctoral studies. Since those subjects with post-secondary education were small in number (n = 8), this group was added to the group with secondary education (n = 35).

Research Findings and Discussion

The findings of this study are presented in relation to the two research purposes: (1) to determine whether elderly clients in an acute care setting perceive they are treated with dignity and respect, and (2) to determine whether elderly clients with a higher (secondary) level of education (as a measure of socioeconomic status) were more likely to be treated with dignity and respect than those with a lower (elementary) level of education.

Data were collected to determine whether length of stay, type of unit (medical or surgical), or sex (male or female) made a difference as to whether elderly clients were treated with dignity and respect.

The items on the questionnaire were selected from the Master Indicator List of the Medicus Quality Assurance Tool by developing an operational definition of dignity and respect. These are behaviors which convey to the client that he/she is worthy of honor, esteem, and is treated with consideration. The questions (see Appendix D) are: Were elderly clients in an acute care setting provided with information (Items 1, 2, 3, and 4 of the questionnaire); were they addressed appropriately (Items 5, 6, and 7 of the questionnaire); were their needs for privacy attended to (Items 8 and 9 of the questionnaire); and was the client given an opportunity to discuss his/her feelings and concerns with the nurse (Item 10 of the questionnaire).

Findings Related to the Research Questions

The responses and discussion related to the research questions will be organized according to the questions generated by the operational definition in order to facilitate a comprehensive presentation.

Research Question #1: Do Elderly Clients in an Acute Care Setting Perceive They are Treated with Dignity and Respect.

Were elderly clients provided with information? The results from Items 1, 2, 3, and 4 of the questionnaire provide data to determine whether elderly clients perceived

they were being treated with dignity and respect by being provided with information. Chi-square computations were performed on the first three (3) items of the questionnaire. The remainder of the items (Items 4-10) will be analyzed by considering the frequency of responses. Due to the small sample and nature of the responses, Items 4-10 were not amenable to significance testing.

The response to Item 1 (Table 1) reveals that 71% of the total group were oriented to the unit and 26% were not. Looking at the differences between the two groups, more of the "younger old" (88%) were shown around the unit when they arrived in hospital. If the clients' condition (physical, mental, or both) on admission to the unit was not amenable to being oriented to the unit the response was coded as not applicable [NA]. For this reason, 3% of the clients were omitted due to their own condition. The difference between the two groups ("younger old" and "older old") is statistically significant (Chi-square = 6.875; p = .009).

The responses to Item 2 (Table 2) of the questionnaire related to introduction to roommates by age differences reveals that 31% of the total group were introduced to their roommate while 55% were not. (For 14% of the respondents the item was not applicable because the client was either in a private room or his/her condition or the condition of other clients were not amenable to introduction.) Examining differences between the two groups shows that 44% of the "younger old" were introduced to their roommates, while 22%

of "older old" were. The difference between the two groups is statistically significant (Chi-square = 5.123; p = .024).

Table 1. Orientation to unit related to age group differences.

Code	Total Group n = 62(%)	Age 65-74 n = 25(%)	Age 75+ n = 37(%)
No	16 (26)	2 (8)	14 (38)
Yes	44 (71)	22 (88)	22 (59)
NA	2 (3)	1 (4)	1 (3)

Table 2. Age group differences related to introduction to roommate.

Code	Total Group n = 62(%)	Age 65-74 n = 25(%)	Age 75+ n = 37(%)
No	34 (55)	9 (36)	25 (67)
Yes	19 (31)	11 (44)	8 (22)
NA	9 (14)	5 (20)	4 (11)

Whether elderly clients were informed of availability of counselors and facilities (Item 3, Appendix D) reveals that 13% of the total group received this information. It was noted that there were no significant differences between the two groups on whether they were informed of the availability of religious counselors and facilities (Chi-square = 0.351; p = .553).

The responses from the total group on whether tests or procedures were explained to them before they were done (Item 4, Appendix D) indicate that 47% had them explained "some of the time", 14% "most of the time", and 23% "all of the time". In comparing the "younger old" with the "older old", 92% of the "younger old" and "78% of the "older old" had procedures explained. While 78% of the "older old" had their procedures explained, 51% had them explained only "some of the time", 13% "most of the time", and 13% "all of the time". The 7 subjects who replied "no" (test and procedures were not explained), were over 74 years of age.

The data related to whether elderly clients in this study were provided with information has been presented. According to the data, there were some elderly clients who were not oriented to their unit, introduced to their roommates, informed of the availability of counselors or had tests and procedures explained before they were done. There were age-related differences; the "older old" (age 75+) were less likely than the "younger old" (65-74) to be oriented to the unit or introduced to their roommates. There were no age-related differences, however, as to whether they were informed of the availability of counselors or facilities.

The current literature, however limited, supports the findings that elderly patients may not be provided with information. Panel members from a Consumer Advisory Panel on Seniors Health Issues (McInnes, 1987) reported that as well as being treated like children they are not provided

information about their condition or treatment. Dolinsky (1984) points out that nurses infantalize the elderly by treating them as if they are incapable of caring for themselves and do not include them in decisions about their own care.

In providing older clients with information regarding orientation to the facility and tests and procedures, the nurse is treating the client with dignity and respect. Providing elderly clients with information assists them to meet their basic human needs for mastery, self-esteem, and love, belongingness, and dependence.

Were elderly clients addressed appropriately? Data from Items 5, 6, and 7 of the questionnaire (see Appendix E) provides information to determine whether elderly clients in the sample were treated with dignity and respect by being addressed appropriately.

The responses to Item 5 indicate that all the nurses introduced themselves to their clients either "some of the time", "most of the time", or "all the time". There were no noticeable differences between the "younger old" and "older old".

Information from Item 6 of the questionnaire reveals that 50% of the total group replied that nurses did not call them by their first name without their permission. Of the remaining 50% who replied that nurses did call them by their first name without their permission, "some of the time",

"most of the time", or "all the time", 36% were the "younger old" and 59% were the "older old".

The response to Item 7 indicates that 40% of the total group were addressed by names other than Miss, Mr., or Mrs.; 35% replied that this behavior occurred only "some of the time". It is noted, however, that 20% of the "younger old", and 46% of the "older old" were addressed by names other than Miss, Mr., or Mrs. "some of the time".

The major finding related to whether elderly clients in an acute care setting are addressed appropriately, indicates that nurses introduce themselves to their clients at least some of the time. Nurses do, however, call their clients by their first name and address them by names other than Miss, Mr., or Mrs. Moreover, the data show age-related differences; the older the client, the more likely they will not be addressed appropriately.

These findings support the view of Burnside (1988), Butler (1977), Dolinsky (1984), Gresham (1976), Grouse (1982), and the elderly themselves (McInnes, 1987). These authors describe the various ways in which older people are treated as children in hospitals. Some of these include: addressing the elderly by their first name whether or not they request it, called by names such as "dear", "good girl", and patting the elderly on the head.

Were elderly clients needs for privacy attended to?

Data from Item 8 and 9 (see Appendix E) provide information

on whether the subjects perceived that their needs for privacy were met.

The responses to Item 8 reveal that all of the respondents indicated that their privacy was ensured by the curtain being drawn and/or door closed during examination or treatment "all the time" (81%) or "most of the time" (13%). There were no noticeable age-related differences.

Data from Item 9 indicates that 82% of the total group did feel inappropriately exposed during a bath, exam, or procedure. There were no age-related differences.

The major findings are that there were some respondents who did not have their needs for privacy met. There were, however, no age-related differences.

The current literature supports the findings. According to Steffl (1984a), professional care givers are often negligent in using bed screens, closing doors, and allowing some personal space. Stillman (1978) states that hospitalized individuals usually experience a loss of privacy and control over their bodies and the surrounding area. They are deprived of privacy to perform the most basic bodily functions (Kemp, 1978).

Were elderly clients given an opportunity to discuss feelings and concerns with a nurse? Item 10 of the questionnaire (see Appendix E) indicates that 40% of the total group of subjects were not provided with an opportunity to discuss their feelings and concerns with a

nurse. A greater percentage (49%) of the "older old" than the "younger old" (28%) were not provided with the opportunity.

The current literature supports the findings that nurses do not provide elderly clients with the opportunity to discuss their feelings and concerns. Several authors (Burnside, 1988; Ebersole & Hess, 1985; Jackson, 1984) note that, in acute care units, older clients are given insufficient time to ask questions and are given little opportunity to participate in any decision-making. Gioiella and Bevil (1985) argue that the nurse should communicate regularly with clients about their progress, reassure them about their condition, and generally provide the time for the patient to verbalize their worries or concerns.

Because an increased level of anxiety interferes with the client's ability to perceive and interpret the experiences of hospitalization correctly, the nurse should make regular assessments of the elderly clients' anxiety level (Burnside, 1988; Ebersole & Hess, 1985; Gioiella & Bevil, 1985). To facilitate communication, all older people should be greeted in a warm, friendly manner and the nurse should be patient and supportive.

Research Question #2: Are Elderly Clients with a Higher Socioeconomic Status More Likely to be Treated with Dignity and Respect

Were elderly clients provided with information? The results from Items 1, 2, 3, and 4 of the questionnaire (see

Appendix F) provide data to determine whether there were differences related to the level of education attained (used as a measure of socioeconomic status) and whether elderly clients were provided with information.

The responses to Item 1 of the questionnaire shows that there are no noticeable differences between the two groups (elementary and secondary education completion) in whether the client was oriented to the unit.

Respondents who had an elementary school education (67%) were less likely than those with a secondary school education (46%) to be introduced to their roommates (Item 2 of the questionnaire). The results, however, were not statistically significant (Chi-square = 1.268; p = .260). Responses to Item 3 of the questionnaire showed that many clients were not informed of the availability of religious counselors or facilities. There were, however, no significant differences between the two groups (Chi-square = 0.721; p = .396).

The data for Item 4 of the questionnaire show that clients with a secondary education may be more likely to have had procedures explained to them before they were done, while 67% of the subjects with an elementary school education had tests explained to them "some of the time", only 32% of those with secondary education did. But, 34% of those with a secondary education had procedures explained "all the time", while only 7% of those with an elementary education did.

Although, in some instances, differences between different levels of education (elementary or secondary) were small, the data showed that a greater percentage of elderly clients with a higher level of education were more likely to be introduced to their roommates, be informed of available services and facilities, and be more likely to have tests and procedures explained to them before they were done. These findings are in keeping with the literature review (Chapter 2). Henretta and Campbell (1976) point out that the higher the individual's socioeconomic class, the greater the likelihood of maintaining status for a longer time because they have resources that given them power in social relationships. It may be argued that clients with a higher level of education, because of their perceived power in social relationships, obtain the information by requesting it.

Were elderly clients addressed appropriately? Data from Items 5, 6, and 7 of the questionnaire (see Appendix F) provide information to determine if elderly clients in the sample were being treated with dignity and respect by being addressed appropriately.

The responses to Item 5 revealed that nurses usually introduced themselves to their elderly clients, except they introduced themselves more frequently to those with a secondary education.

The data from Item 6 indicate 66% of the elementary group and 80% of the secondary group were called by their

first name without their permission. Before collapsing the secondary and post-secondary group, however, it is noted that only 12% of those respondents with a post-secondary education were called by their first name; 88% of the respondents indicated that they were not addressed by their first name without their permission while 33% of the elementary group were (see Item 6a, Appendix F).

The results of Item 7 suggest that clients with a lower level of education may be more likely than those with secondary or post-secondary school education to be addressed by names other than Miss, Mr., and Mrs., but the differences seem minimal.

The major finding related to whether elderly clients in an acute care setting are addressed appropriately, indicates that nurses introduce themselves to their clients at least some of the time. Nurses do, however, call their clients by their first name and address them by names other than Miss, Mr., or Mrs. The data suggest that the higher the client's socioeconomic status (as determined by level of education), the more likely they will be addressed appropriately.

Studies which examine the elderly clients' socioeconomic status and how elderly clients are addressed with any specificity are non-existent. The results found in this study, however, can be supported by Henretta and Campbell (1976), and Butler (1977) on the basis of social class (mentioned earlier).

Were elderly clients' needs for privacy attended to?

The results of Item 8 and 9 of the questionnaire (see Appendix F) provide data to determine if the older person's need for privacy was attended to.

The results of Item 8 reveal that there is only a 10% difference between the elementary and secondary educated group; 81% of the elementary school group and 91% of the secondary school group indicated that the curtain was drawn and/or the door closed during an examination or treatment. Data for Item 9 indicate that a greater percentage of those with a secondary school education (91%) than elementary education (74%) felt they were inappropriately exposed. Only 9% of the secondary group compared with 26% of the elementary group felt inappropriately exposed ("some of the time", "most of the time", or "all the time") during a bath, exam, or procedure.

The major findings related to whether the elderly client's need for privacy is attended to, reveal that there were some differences to show that some of the respondents did not have their needs for privacy met.

The current literature supports this finding. Clients with a higher socioeconomic status were shown to be more likely to have their needs for privacy met than clients of a lower socioeconomic status. Brown (1969) reported that clients who are socially valued were observed to receive extra care from nurses. Henretta and Campbell (1976) found

(as mentioned earlier) that clients with a higher socioeconomic status have resources that give them power in social relationships.

Were elderly clients given an opportunity to discuss feelings and concerns with a nurse? The data from Item 10 of the questionnaire (see Appendix F) showed that a greater proportion of clients with a secondary school education (23%) than elementary school education (15%) were given an opportunity to discuss their feelings "most of the time" or "all the time". The difference is small, however, but could be explained by studies cited in previous paragraph.

Other Findings

Differences related to length of stay and type of unit (medical or surgical) could not be determined since the information was confounded. Confounding factors are unwanted group differences between comparison groups that occur in surveys (Weldon, 1986). Comparisons in this group are "confounded" because the group was not similar in all relevant aspects. For example, the "older old" group was larger (n = 37) than the "younger old" (n = 25). While there was a similar number of males and females in the "older old" group, the "younger old" group contained more men. The number of subjects by gender and length of stay were also related; although the "long stay" group had an equal number of males and females, the "short stay" group contained more men.

Group differences were not ascertained since sample sizes were too small to look at interactions between variables (age, gender, education, LOS, and unit). Therefore, each factor was examined separately and no attempt was made to adjust for multiple significance tests. Therefore, these results must be regarded as descriptive only.

Gender differences. Nurses tended to address women by names other than Miss or Mrs. more frequently than they addressed men other than Mr. Procedures were explained more frequently to men than women and men reported more responses indicating "treatment with dignity and respect" on Items 4 to 10.

Length of stay. There were no noticeable differences between length of stay groups, though people who stayed longer tended to be older. More responses indicating "treatment with dignity and respect" were reported by the "short stay" subjects.

Type of unit. Differences between type of unit (medical or surgical) were minimal. Clients in surgical units reported more responses indicating "treatment with dignity and respect" on 6/7 items (there were more men in surgical units than women).

In examining group differences, a significant finding is that fewer females reported responses indicating "treatment with dignity and respect" than men. Though

literature addressing gender differences in caring for hospitalized clients is scarce, one study by Forgan Morle (1984) found that nurses provided explanations more frequently to elderly men than they did to elderly women. L'Esperance (1979) reported that physicians and nurses often respond negatively to women's questions, provide inadequate information, and lecture their clients instead of encouraging them to participate in health care decisions.

In conclusion, the findings in this study show that the "younger old" who were male and attained a higher level of education were more likely to be treated with dignity and respect.

The elderly client's perception of his/her nursing care in this study supports other reports and studies which investigate the quality of care the elderly receive (Campbell, 1971; McInnes, 1987; Health and Welfare Canada, 1982; Podnieks, 1983). These authors say that the negative attitude of nurses toward aging and the elderly is one of the factors that contributes to an inferior quality of nursing care; nurses who hold negative attudies toward the elderly will engage in behaviors which may not be therapeutic or may be detrimental to the best interest of the elderly client (Brower, 1981; Campbell, 1971; Lueckenotte, 1987; Penner et al., 1984). Negative attributions may be internalized by an elderly person, and may subsequently influence his or her beliefs and

self-concept (Cherry, 1981; Kuypers & Bengston, 1973). In other words, the elderly develop perceptions about themselves on the basis of attitudes of others toward them.

It is generally held that attitudes are derived, at least partially, from the prevalence of cultural stereotypes (Kogan, 1979; Levin & Levin, 1980). Negative stereotypes about aging and growing old are inculcated through the socializaton process. In turn, these stereotypes represent incorrect assumptions, faulty reasoning, and misperceptions. If accepted as fact, they influence our behavior and attitude toward the elderly. Negative attitudes toward the elderly lower the status of older people and decrease the frequency and quality of social interaction with them.

Some elderly, however, possess status characteristics that enable them to retain power (Henretta & Campbell, 1976). This releases them from some of the constraints of aging imposed on others by virtue of age. These authors reported that the higher the individual's social class, the greater the likelihood of maintaining status for a longer period of time. These observations support the findings in this study which found that nurses may present themselves differently to clients with a higher socioeconomic status.

It seems reasonable to suggest then that women in this study were less likely to be treated with dignity and respect than men because of status. The greatest number of older people are women and many of these women are economically dependent.

Women's social status declines with age (Dulude, 1981) in contrast to that of men, who grow in "character". This means that as a population ages, it becomes more and more characterized by old, poor women with low social status. The symbolic interactionist view suggests that different dress, speech, and behavior patterns are selected in order to present a self considered appropriate to the specific situation. It may be that elderly women may be less likely to be treated with dignity and respect because they are perceived to have a lower status.

Lillard (1982) points out that elderly women may be affected negatively by the double bias of ageism and sexism. In addition to the negative attitudes and practices that discriminate against the aged (ageism) elderly women are stereotyped in ways that are directly related to sexism; they are economically disadvantaged, poorly insured, and socially isolated.

There is no literature which addresses the combined impact of ageism and sexism on the nursing care of aged women (Lillard, 1982). Since both biases are present in the culture and are known to affect health care as separate entities, this author asserts that it is reasonable to speculate about the significance of the two factors operating simultaneously. The implication for aged women is that they may be the least valued and most underserved patient group.

Nursing approaches and actions are shaped by input from many facets of society: cultural values filter through social and political systems to affect nursing education, practice and care delivery (Gioiella & Bevil, 1985; Lillard, 1982). According to these authors, nursing programs frequently ignore health needs of the elderly. Too, the nurse may be influenced by society's values even before they are filtered through organized institutions. Wiesstein (1971) states that the social context is the major detriment to behavior; people will act as they are expected to even if those expectations are transmitted indirectly. In spite of pressures on nurses to act autonomously based on client well-being alone, if the nurse's cultural group is predominantly sexist, there is a likelihood that some of the nursing care will reflect (consciously or unconsciously) those sexist values.

According to Jourard (1974), people's views of themselves are strongly influenced by other's definition of them. If nurses project a negative attribute on the elderly client, the attribute may be internalized; conversely, if the nurse projects an attribute of dignity and respect, the elderly client's self-concept is maintained or enhanced.

Summary

This chapter has presented the data which were obtained to determine whether there are differences in perceptions related to age and socioeconomic status. Other factors such

as length of stay, sex, and type of unit (medical or surgical) were also described. The results indicate that the "younger old" males and those with a higher level of education (socioeconomic status) were more likely to be treated with dignity and respect.

CHAPTER 5

Summary, Conclusions, Implications, and Recommendations

Summary and Conclusions

This study was designed to investigate whether elderly clients in an acute care setting perceived they were treated with dignity and respect, and to identify whether elderly clients with a higher socioeconomic status were more likely to be treated with dignity and respect than those with a lower socioeconomic status. After the data were collected the investigator proceeded to identify group-related differences (age, sex, education, length of stay, and type of unit) and whether there were any differences in relation to dignity and respect. The impetus for this study emanated from empirical findings and information in the literature.

Sixty-two subjects who were between 65 and 91 years of age were selected from medical and surgical units of two major teaching hospitals using a convenience sampling technique. These subjects were in hospital at least five days and were alert and oriented during their hospitalization. They were asked to answer "fixed-alternative" questions on a questionnaire (Appendix D) in an interview in their home within three days after they were discharged from the hospital.

The following are major findings and conclusions of the study:

1. Registered nurses from acute care settings do not consistently orient the elderly client to their unit, introduce them to their roommates, or inform them of the availability of counselors or facilities. The elderly over 75 years of age were less likely than the younger group (65-74) to be oriented to the unit or introduced to their roommates. There were no age-related differences on whether they were informed of the availability of counselors or facilities.

2. Those respondents who had a higher level of education were more likely to be introduced to their roommates and informed by nurses of available services and facilities.

3. All the respondents indicated that the nurses introduced themselves "some of the time", "most of the time", or "all the time", although more frequently to clients with higher socioeconomic status. Half of the respondents revealed that nurses called them by their first name without their permission "some of the time", "most of the time", or "all the time", and the older group was more likely than the younger group and those with a lower socioeconomic status to be called by their first name. Nurses were found to address their clients by other than

Miss, Mr., or Mrs., but this behavior occurred more frequently in the "older old" and those with a lower socioeconomic status.

4. All of the respondents revealed that the curtains were drawn or the door was closed during an examination or treatment "most of the time" or "all the time"; there were no differences between the older and younger group or socioeconomic status. The nurses explained tests and procedures to their elderly clients "some of the time", "all the time", or "most of the time" but with greater likelihood in the "younger old" and those with a higher socioeconomic status. Although some respondents felt inappropriately exposed during a bath, exam, or procedure; there were no significant differences between the "older old" and "younger old"" group. There was some indication, however, that people with a higher socioeconomic status are less likely to be inappropriately exposed than those with a lower socioeconomic status.

5. The respondents revealed that they were provided with an opportunity to discuss their feelings or concerns with the nurse "some of the time", "most of the time", or "all the time". The "younger old" and those with a higher socioeconomic status were more likely to be provided with this opportunity.

The evidence in this study suggests that the elderly client in an acute care setting may not be treated with

dignity and respect. The evidence is made more convincing by examining the younger and older groups of the elderly population sample and finding that the older client is less likely than the younger client to be treated with dignity and respect. Moreover, females were less likely than males to be treated with dignity and respect.

Some differences existed between the client's socioeconomic status (as determined by level of education) and the degree to which the client is treated with dignity and respect. Although there were no significant differences on whether clients were provided with information, those clients who had a higher socioeconomic status were more likely to be treated with dignity and respect than those with a lower socioeconomic status on Items 4-10 of the questionnaire.

This study suggests that a significant number of elderly clients perceive they are not treated with dignity and respect. The investigator will discuss these findings with reference to their implications for nursing.

Implications

It has been estimated that by year 2031 about 25% of the population in Canada will be 65 years or older. The increase in the proportion of elderly will have far reaching demands upon those who provide nursing services. When today's nursing students reach the prime of their careers, 75% of their nursing practice time will be spent with the

elderly. Because of the demographic trend, the findings of this study have significant implications for nursing practice, nursing education, and nursing research.

Nursing Practice

Several factors have been identified in the literature (Chapter 2) as having the potential to adversely affect elderly clients in an acute care environment. The attitudes of caregivers, the normal aging process, chronic disease, being ill in a strange environment, and acute illness are some of the conditions interacting to make hospitalization a potentially harmful experience. Such people may not only be ill, but tend also to be largely isolated from family, friends, and familiar surroundings.

Nurses who work in acute care hospitals are responsible for planning, implementing, and evaluating nursing care for their clients, young or old. As is apparent from the literature addressing nursing ethics, one crucial responsibility of nursing is that of maintaining the dignity and respect and individuality of hospitalized old people. The results of this study indicate, however, that some elderly clients (particularly those of lower status and women) often are not provided with information, addressed appropriately, do not have their needs for privacy attended to, or are not provided with an opportunity to discuss their fears or concerns.

These findings suggest that the nursing management of

acutely ill older adults in the hospital setting is a matter of serious ethicolegal consideration. According to the Canadian Nurses Association Code of Ethics (1985), the nurse is obliged to encourage client autonomy, include the client in the decision-making process, and cultivate respectful and dignified treatment of the client.

Negative attitudes and perceptions of the aged and aging held by nurses can have detrimental effects on elderly clients. A number of studies have documented the presence of negative attitudes by nurses with some evidence suggesting attitude influences treatment of the elderly client. According to Ebersole and Hess (1985), the myths dangerous to the elderly client are those that perpetuate the idea that the aged are dependent and the young are independent. Clients subjected to care practices which defy gerontological care principles may regress and become increasingly dependent.

If the elderly are to survive acute hospitalization and receive humane and therapeutic care, very specific nursing interventions are required. Burnside (1988) asserts that the nurse's role is to support the older person's ability to become informed about the acute care setting, organize the information, and assist the older person's ability to adapt to the new environment in a manner that enables the older person to recover from the acute illness. Ebersole and Hess (1985) have identified the generative functions of

productivity and problem-solving ability as essential to the maintenance of self-esteem in the elderly and have suggested that the nurse's role is to assist in development of these abilities. Providing the older adult with information allows and encourages participation in one's own health care and helps to strengthen feelings of control and autonomy. According to Burnside (1988) some elderly become ill in ways which are secondary to nontherapeutic care. Nurses must be aware of the risks of hospitalization for the elderly.

Selected studies show how limited knowledge, skills and attitudes of nurses make hospitalization a potentially harmful experience for elderly clients (Bossenmaier, 1982; Gunter, 1983; Lueckenotte, 1987). According to these authors, hospitalization emphasizes the elderly client's physical deterioration and loss of health, mobility, and independence. Even when they are capable of self-care, nurses may believe it is faster to do things for them, thus reinforcing the client's dependent position. These losses weaken the elderly client's feelings of self-confidence, sense of self-esteem, and loss of control over their life-style (Burnside, 1988; Gioiella & Bevil, 1985). According to these authors, helping the elderly client begins with the admission procedure. As soon as possible, the nurse should provide the client with a thorough orientation to the physical setting, routines, roommates, and personnel. Older clients should know the locations of their bed, bathroom, and lounge.

Older people often have difficulty accurately perceiving events because of various sensory losses (Chodil & Williams, 1970; Worrell, 1977). Because of previous experiences as well as insufficient information, older clients may become anxious and agitated. Several authors (Bossenmaier, 1982; Gioiella & Bevil, 1985; Forgan Morle, 1984) point out that explanations before procedures being performed are seldom given. According to these authors, to reduce the anxiety associated with diagnostic tests, older clients require clear explanations of their purpose, the preparation required, and how they can assist during the test or procedure.

There is a reciprocal relationship between client and the attitudes of nurses (Lillard, 1982; White, 1977). For example, clients who cannot care for themselves or are viewed as having fewer positive attributes may not be valued by the nurse. According to White (1977) clients derive ideas about themselves according to how they interpret the behavior of the nurse; thus, their attitudes about themselves are related to dignity, respect and esteem shown by the nurse either directly or indirectly through their actions.

Studies suggest that those clients who are less socially valued or have fewer positive attributes are more likely to receive poorer care (Burnside, 1988; Gioiella & Bevil, 1985; White, 1977). According to White (1977) we

need to be concerned both for the extent to which negative attitudes are conveyed to clients and for the extent to which positive attitudes are not expressed appropriately, or appropriate behaviors do not occur.

Although nursing literature recognizes ageism as a real threat to the care of the aged, the recent literature does not discuss sexism among nurses or its relationship to client care (Lillard, 1982). The implication for aged women, she states, is that they are the least valued and most underserved client population. According to Lillard, options for funding research, education and change projects focused on improving the health care of elderly women needs to become paramount.

Every nurse is responsible and accountable for the nursing practice delivered to aging clients. It is also the responsibility of every nurse to provide nursing care based on a sound, scientific knowledge base.

Nursing Education

Positive attitudes toward the elderly are required to achieve optimal care for the elderly which meets their need for dignity and respect. Although findings have been mixed, there are studies which show that nurses who have taken a course of study in Gerontological Nursing demonstrate more positive attitudes toward the elderly (Gomez, Otto, Blattstein, & Gomez, 1985; Stanley & Burggraf, 1986; Wilhite & Johnson, 1976). Therefore, continuing education (in

general or specific areas) in universities, colleges, and health care institutions should be one of the strategies used to maintain or increase positive attitudes about aging.

The lack of emphasis in nursing education on knowledge and application of gerontological nursing principles identifies a need for in-service education. A nursing staff development program must include education in theories of aging, normal aging (physiologic and psychosocial) changes, sensitivity to stereotypes, and to develop strategies to assist nurses to incorporate new knowledge into nursing practice.

Educational programs for gerontological nursing staff must address the dynamics of the nurse-client interactions. For example, nursing staff could be taught how to reduce dependent behaviors on the part of clients. Nursing staff also could be made aware of how the meaning of their attitudes and behavior is interpreted by the client. Additionally, the organizations for which nursing staff work must consider how their policies and practices may be contributing toward their staff's attitudes toward and perceptions of their elderly clients.

Nursing practice administrators can play a major role in maintaining and increasing positive attitudes toward the elderly and promoting the quality of care of the aging client. This can be achieved by allocating resources for staff education (including orientation programs),

establishing standards of nursing care, and believing that increased knowledge is paramount to the delivery of quality care.

Strategies should be developed to enhance the image of the nurse whose practice includes elderly clients. Primary nursing and provision of clinical nurse specialists whose expertise is in gerontological nursing should be promoted. These nurses would function as clinical nurse practitioners, consultants, educators, and researchers in addition to providing leadership and acting as role models for other nurses. Moreover, human dignity and respect of older adults must become our immediate agenda for consideration within schools of nursing and curriculum planning.

Nursing Research

Nursing research provides a firm foundation for all areas of nursing. Unfortunately, nursing research regarding the elderly client's perception of his/her nursing care is very limited.

Further research would be useful in substantiating the findings discussed in this thesis. First, replication of this study is recommended using a probability sampling technique. The problem of an accidental sampling technique (nonprobability sampling) is that available subjects might not be representative of the population with regard to the critical variables being measured (Polit & Hungler, 1983). The second recommendation relates to the measurement of

dignity and respect. Further investigation to describe perception of dignity and respect would be of value.

This researcher examined a group of alert and oriented elderly clients. Other elderly clients, who are not alert, need to be investigated as to whether their nursing care ensured their dignity and respect.

This study assumed that personality dimensions are highly dependent on social learning and interaction, and when losses or changes occur in these areas, older persons, like younger persons, begin to question their worth and competence. This in turn can lower their level of self-esteem or change their self-concept, thereby leading to changes in behavior. Research should be conducted to determine the relationship between nursing care which does or does not meet the elderly client's need to be treated with dignity and respect and its effect on self-concept.

This study found males were more likely to be treated with dignity and respect than women. Studies which examine gender differences in the quality of care are scarce. The fact that the greatest number of older people are women and are more commonly found in the ranks of the poor or those on welfare (Dulude, 1981) stimulates the following research questions. To determine: (1) Whether there is a relationship between their lower socioeconomic status and the degree to which elderly women are treated with dignity and respect, and (2) whether nurses' attitudes are more

favorable toward elderly male than elderly female clients. Furthermore, what nursing actions would be most effective in heightening the clients' (male and female) perception of being treated with dignity and respect.

As previously stated, the proportion of elderly people is increasing; by year 2031, an estimated 24% of the population will be over 65 years of age. This has implications for all areas of nursing practice, education, and research. Educationally, nurses must be well prepared for this responsibility. Nursing practice and education should be based on sound research.

REFERENCES

Alford, D. M., (1982). Tips for teaching older adults. Nursing Life, 2, 60-63.

Allen, R. E. (Ed.). (1984). The Oxford dictionary of current english. Great Britain: Cox & Wyman Ltd.

Bahr, R. T. (1987). Adding to the educational agenda. Journal of Gerontological Nursing, 13 (3), 6-11.

Bengston, V. L. (1978). The institutionalized aged and their social needs. In E. Seymour (Ed.), Psychosocial needs of the aged: A health care perspective. Los Angeles: University of Southern California Press.

Blumer, H. (1969). Symbolic interactionism: Perspective and method. New Jersey: Prentice-Hall.

Bossenmaier, M. (1982). The hospitalized elderly: A first look. Geriatric Nursing, 3 (4), 253-256

Bower, F., & Bevis, E. (1979). Fundamentals of nursing practice: Concepts, roles and functions. St. Louis: Mosby, 1979.

Brower, H. T. (1981). Social organization and nurses attitudes toward older persons. Journal of Gerontological Nursing, 7 (5), 293-298.

Brown, M. I. (1969). Patient variables associated with preferences among elderly patients. Paper presented at ANA Nursing Research Conference.

Burnside, I. M. (1988). Nursing and the aged: A self-care approach. New York: McGraw-Hill.

Butler, R. N. (1980). Why survive? Being old in America. New York: Harper & Row.

Butler, R., & Lewis, M. (1977). Aging and mental health: Routine psychosocial approaches. St. Louis: Mosby.

Campbell, M. A. (1987). The UBC model for nursing: Directions for practice. Vancouver, BC: University of British Columbia.

Campbell, M. E. (1971). Study of the attitudes of nursing personnel toward geriatric patients. Nursing Research, 20 (2), 147-151.

Canadian Nurses Association. (1985). Code of ethics for nursing. Ottawa: Author.

Chappel, N. L., Strain, L. A., & Blandford, A. A. (1986). Aging and health care: A social perspective. Canada: Holt, Rinehart & Winston.

Cherry, R. (1981). The aging experience. Singapore: Singapore National Printers.

Chodil, J., & Williams, B. (1970). The concept of sensory deprivation. Nursing Clinics of North America, (5), 453-465.

Coburn, J. (1981). I see and I am silent: A short history of nursing. In D. Coburn, C. D'Archy, P. New, & G. Torrance (Eds.), Health and Canadian society. Toronto: Fitzhenry & Whiteside.

Cooley, C. H. (1922). Human nature and the social order. New York: Scribner.

Curtin, L., & Flaherty, M. J. (1982). Nursing ethics: Theories and pragmatics. Bowie, MD: Robert Brady.

Davis, R. W. (1968). Psychological aspects of geriatric nursing. American Journal of Nursing, 68 (4), 802-804.

Dolinsky, E. H. (1984). Infantalization of the elderly: An area for nursing research. Journal of Gerontological Nursing, 10 (9), 12-19.

Dulude, L. (1981). Pension reform with women in mind. Ottawa: Advisory Council on the Status of Women.

Ebersole, P., & Hess, P. (1985). Toward healthy aging: Human needs and nursing response. St. Louis: Mosby.

Elbeck, M. A. (1986). Client perception of nursing practice. Nursing Papers, 18 (2), 17-23.

Elliott, B., & Hyberton, D. (1982). What is about the elderly that elicits a negative response? Journal of Gerontological Nursing, 8 (10), 568-571.

Fawcett, J. (1984). Analysis and evaluation of conceptual models of nursing. Philadelphia: Davis.

Forbes, W. F., Jackson, J. A., & Kraus, A. S. (1987). Institutionalization of the elderly in Canada. Toronto: Butterworths.

Forgan Morle, K. M. (1984). Patient satisfaction: Care of the elderly. Journal of Advanced Nursing, 9, 71-76.

Fromm, E. (1955). The sane society. New York: Rhinehart.

Futrell, M., & Jones, W. (1977). Attitudes of physicians, nurses and social workers toward the elderly and health maintenance services for the elderly: Implications for health manpower policy. Journal of Gerontological Nursing, 3 (3), 41-46.

George, L., & Bearon, L. (1980). Quality of life in older persons: Meaning and measurement. New York: Human Sciences Press.

Gioiella, E. C., & Bevil, C. W. (1985). Nursing care of the aging client: Promoting healthy adaptation. Norwalk, CT: Appleton-Century-Crofts.

Goebel, B. L. (1984). Age stereotypes held by student nurses. Journal of Psychology, 116 (2), 249-250.

Goffman, E. (1959). The presentation of self in everyday life. New York: Doubleday.

Gomez, G. E., Otto, D., Blattstein, A., & Gomez, A. (1985). Beginning nursing students can change attitudes about the aged. Journal of Gerontological Nursing, 11 (1).

Gresham, M. L. (1976). The infantalization of the elderly: A developing concept. Nursing Forum, 15 (196), 195-210.

Grouse, L. (1982). Dirtball. Journal of the American Medical Association, 247 (22), 2059-3060.

Gunter, L. J. (1983). Ethical consideratins for nursing care of older patients in the acute care setting. The Nursing Clinics of North America, 18 (2), 411-421.

Gutman, G., Gee, E., Bojanowski, B., & Mottet, D. (1986). Fact book on aging in British Columbia. Burnaby, BC: Simon Fraser University, Gerontology Research Center.

Hatton, J. (1977). Nurses attitude toward the aged: Relationship to nursing care. Journal of Gerontological Nursing, 3 (3), 21-26.

Health and Welfare Canada. (1982). Canadian government report on aging. Ottawa: Author.

Hegyvary, S., & Haussmann, R. (1975). Monitoring nursing care quality. Journal of Nursing Administration, (6), 17-26.

Henretta, J., & Campbell, R. (1976). Status attainment and status maintenance: A study of stratfication in old age. American Sociological Review, 41 (6), 981-992.

Jackson, M. (1984). Geriatric rehabilitation on an acute care medical unit. Journal of Advanced Nursing, (9), 441-448.

Jourard, S. M. (1974). Healthy personality. New York: Macmillan.

Kemp, J. (1978). Planning hospital care. Nursing Times, 74 (5), 198-201.

Kogan, N. (1979). Beliefs, attitudes and stereotypes about old people: A new look at some old issues. Research on Aging, 1, 17-36.

Kuypers, J., & Bengston, B. (1973). Social breakdown and competence: A model of normal aging. Human Development, 16, 181-201.

Leddy, S., & Pepper, J. M. (1985). Conceptual bases of professional nursing. Philadelphia: Lippincott.

Levin, J. S., & Levin, W. (1980). Prejudice and discrimination against the elderly. California: Wadsworth.

Lillard, J. (1982). A double-edged sword: Ageism and sexism. Journal of Gerontological Nursing, 8(11), 630-634.

L'Esperance, C. M. (1979). Home birth - a manifestation of aggression? Journal of Obstetrics and Gynecological Nursing, 8, 227-230.

Lueckenotte, A. (1987). Sharpen skills in hospital settings. Journal of Gerontological Nursing, 13, 12-19.

Mantle, J. (1988a). Nursing practice in long-term care agencies. In A. Baumgart & J. Larsen (Eds.), Canadian nursing faces the future: Development and change. St. Louis: Mosby.

Mantle, J. (1988b, April). The state of the art of gerontological nursing. Paper presented at the meeting of the British Columbia Gerontological Nurses Group, Vancouver, BC.

Maslow, A. H. (1968). Toward a psychology of being. New York: Van Nostrand.

Maslow, A. H. (1970). Motivation and personality. New York: Harper & Row.

McInnes, C. (1987, December 2). Treat us with dignity, don't call us "dear", elderly demand. Globe and Mail, pp. A16.

Mead, G. H. (1934). Mind, self and society. Chicago: University of Chicago Press.

Meltzer, B. N., Petras, J. W., & Reynolds, L. T. (1977). Symbolic interactionism: Genesis, varieties and criticism. Boston: Routledge & Kegan Paul.

Natkins, L. (1982). "Hi Lucille, this is Dr. Gold". Journal of American Medical Association, 247 (17), 2415.

Nelson, B. K. (1973). Study indicates which patients nurses don't like. Modern Hospital, 8, 70-72.

Pastalan, L. (1970). Spatial behavior of older people. Ann Arbor: University of Michigan.

Penner, L., Ludenia, K., & Mead, G. (1984). Staff attitudes: Image or reality? Journal of Gerontological Nursing, 10 (3), 110-117.

Podnieks, E. (1983). Abuse of the elderly. The Canadian Nurse, 79 (5), 34-35.

Polit, D., & Hungler, B. (1983). Nursing research: Principles and methods. Philadelphia: Lippincott.

Registered Nurses' Association of British Columbia. (1984). Standards for nursing practice in British Columbia. Vancouver: Author.

Reid, D., Hass, G., & Hawkins, D. (1977). Focus of desired control and positive self-concept of the elderly. Journal of Gerontology, 32, 441-450.

Roos, N., Shapiro, E., & Roos, L. (1984). Aging and the demand for health services: Which aged and whose demand? The Gerontologist, 24 (1), 31-36.

Rossman, D. (1979). Clinical geriatrics. Philadelphia: Lippincott.

Rowe, J. W. (1985). Health care of the elderly. New England Journal of Medicine, 312 (13), 827-835.

Roy, C. (1976). Introduction to nursing: An adaptation model. New Jersey: Prentice-Hall.

Schonfield, D. (1982). Who is stereotyping whom and why? The Gerontologist, 22, 267-272.

Silversides, A. (1987, April 27). Aging society's impact on cost of health care is called exaggerated. Globe and Mail, pp. A16.

Smith, S. P., Jepson, V., & Perloff, E. (1982). Attitudes of nursing care providers toward elderly patients. Nursing and Health Care, 3, 93-98.

Stanley, M., & Burggraf, V. (1986). The path of the past shaping the future. Journal of Gerontological Nursing, 12 (7), 30-34.

Statistics Canada. (1980). Population projection for Canada and the Provinces, 1976-2001. Ottawa: Author.

Steffl, B. M. (1984a). Attitudes toward aging and gerontological nursing. In B. M. Steffl (Ed.), Handbook of Gerontological Nursing (pp. 17-24). New York: Van Nostrand Reinhold.

Steffl, B. M. (1984b). Basic human needs and developmental tasks of aging. In B. M. Steffl (Ed.), Handbook of gerontological nursing (pp. 39-49). New York: Van Nostrand Reinhold.

Stillman, M. (1978). Territoriality and personal space. American Journal of Nursing, 10, 1670-1672.

Stone, O., & Fletcher, S. (1986). The seniors boom: Dramatic increases in longevity and prospects for better health. Statistics Canada - Population Studies Division. Ottawa: Minister of Supply and Services Canada.

Storch, J. L. (1988). Ethics in nursing practice. In A. Baumgart & J. Larsen (Eds.), Nursing faces the future: Development and change. St. Louis: Mosby.

Storlic, F. J. (1982). The reshaping of the old. Journal Gerontological Nursing, 8, 555.

Stryker, S. (1980). Symbolic interactionism: A social structural version. London: Benjamin/Cummings.

Taylor, K. H., & Harned, T. L. (1978). Attitudes toward old people: A study of nurses who care for the elderly. Journal of Gerontological Nursing, 4 (5), 43-47.

Thomas, W. (1934). The definition of the situation. In W. Thomas (Ed.), The unadjusted girl. Boston: Little, Brown.

Weisstein, N. (1971). Psychology constructs the female. In V. Gornick & B. Moran (Eds.), Women in sexist society. New York: Basic Books.

Weldon, K. L. (1986). Statistics: A conceptual approach. New Jersey: Prentice-Hall.

White, C. M. (1977). The nurse-patient encounter. Attitude and behaviors in action. Journal of Gerontological Nursing, 3, 16-21.

Wilhite, M. J., & Johnson, D. M. (1976). Changes in nursing students' stereotypic attitudes towards old people. Nursing Research, 25 (6), 62-66.

Wolk, R. L., & Wolk, R. B. (1971). Professional workers attitudes toward the aged. Journal of the American Geriatrics Society, 19, 624-639.

Worrell, J. D. (1977). Nursing implications in the care of the patient experiencing sensory deprivation. In Kintzel, L. D. (Ed.), Advanced concepts in clinical nursing. Philadelphia: Lippincott.

Zimbardo, P. G., & Ebbesen, E. B. (1969). Influencing attitudes and changing behavior. Reading, MA: Addison & Wesley.

APPENDIX A

Information Letter

I am Josephine Steckler, a registered nurse in the Masters of Nursing program at the University of British Columbia. I am interested in learning more about how older adults view some aspects of their nursing care. It is believed that the findings of this study will help nurses provide better nursing care for older people.

I would like your permission to interview you about the nursing care you received during your stay in the hospital. The interview will take about 20 minutes and will take place in your own home, at your convenience within three (3) days after you leave hospital. All information will be confidential. You will be free to interrupt the interview at any time, to ask questions, rest, or to stop the interview entirely.

If you are willing to take part in the study you will be asked to sign a consent form and I will contact you to arrange a time for the interview. The questionnaire that I fill out during the interview will be shared with my two professors only. After my research report is written, the completed questionnaire will be destroyed.

Although your participation would be of great value, you should understand that you may withdraw from the study at any time or choose not to take part without prejudicing the care of yourself or your family member now or in the future.

If you have any questions concerning this study, please feel free to ask. You may reach me by leaving a message at the university at and I will return your call.

Thank you

Josephine Steckler, R.N., B.A.

APPENDIX B

Consent Form

I agree to participate in the research study conducted by Josephine Steckler, a graduate student in Nursing at the University of British Columbia.

I have read the information letter explaining the study and understand that:

1. I will be asked questions about the nursing care I received while I was hospitalized.

2. The interview will be recorded on a questionnaire and will last about 20 minutes.

3. The questionnaire will be available only to Josephine and her two professors and will be destroyed after the thesis has been accepted.

4. The information obtained will be confidential.

5. My refusal to participate or my desire to withdraw from the study at any time will be respected and will not affect any medical or nursing care I may require in the future.

All the questions about the study have been answered by Josephine Steckler. I have received a copy of the information letter and consent form and I agree to participate in the study.

_____ Signed

_____ Date

APPENDIX C

Letter to Medical and Surgical Nursing Directors for Approval to Conduct Nursing Research

My name is Josephine Steckler. I am a graduate student in nursing at the University of British Columbia carrying out a research study for a Master's Thesis. The study is designed to determine whether elderly clients in an acute care hospital perceive they were treated with dignity and respect.

The information from the selected clients will be elicited after they leave the hospital. They will be at least 65 years of age, have been in hospital no less than five (5) days and will have been alert and oriented to time, place and person during their entire hospitalization.

Prior to leaving hospital the clients who meet the established criteria will be approached and provided with a written and verbal explanation of the study and consenting clients will be asked to sign the consent form at this time.

A plan to seek consent from prospective clients before they leave the hospital will be developed according to the established research protocol of the hospital. The investigator will meet with the head nurses to enlist their support in selecting clients who meet the criteria and are being discharged from hospital.

Thank you for your cooperation in assisting me to accomplish this research study.

Yours truly

Josephine Steckler

APPENDIX D

Research Tool

Age of client _____

Highest level of education obtained _____

Number of days in hospital _____

Nursing unit - Medical / Surgical

Sex _____

To the following items code

(a) no
(b) yes
(c) not applicable

1. "Were you shown around the unit when you arrived?"

   Note: Examples of orientation include showing location of bathroom, way to call nurse, place to put personal belongings.

2. "When you were admitted to the unit did someone introduce you to your roommate?"

   Note: Code NA if patient in private room.

3. "Have you been informed of the availability of religious counselor and facilities?"

   If yes, ask patient:
   "Was this Information provided to you by a nurse?"

   Note: Code NA if information was given by clerk or hospital brochure.

Nursing Process Quality Monitoring Instrument (Medicus Canada). Used with permission (Sue Hegyvary, personal communication, September 12, 1988).

To the following items code

(a) no
(b) yes some of the time
(c) yes most of the time
(d) yes all of the time
(e) not applicable

4. "Have you had any tests or procedures while you've been in this hospital?"

   If yes, ask:
   "Were they explained to you by your nurse before they were done?"

5. "Have your nurses introduced themselves to you?"

6. "Have your nurses called you by your first name without your permission?"

7. "Have your nurses addressed you by names other than Miss, Mr., or Mrs.?"

   Note: Other names include granny, grampa, dear, etc.

8. "When you had an examination or treatment and a nurse was in the room, were the curtains drawn around you or was the door closed?"

9. "Have you felt inappropriately exposed during a bath, exam, or procedure while on this unit?"

10. "While you were in the hospital, were you given an opportunity to discuss your feelings or concerns with your nurse?"

APPENDIX E

Results of Items from Questionnaire for Total Group (age 65-91), "Younger Old" (age 65-74), "Older Old" (age 75-91), Related to Dignity and Respect

Item 1. Orientation to unit related to age group differences.

Code	Total Group n = 62(%)	Age 65-74 n = 25(%)	Age 75+ n = 37(%)
No	16 (26)	2 (8)	14 (38)
Yes	44 (71)	22 (88)	22 (59)
NA	2 (3)	1 (4)	1 (3)

Item 2. Age group differences related to introduction to roommate.

Code	Total Group n = 62(%)	Age 65-74 n = 25(%)	Age 75+ n = 37(%)
No	34 (55)	9 (36)	25 (67)
Yes	19 (31)	11 (44)	8 (22)
NA	9 (14)	5 (20)	4 (11)

Item 3. Knowledge about availability of religious counsellors and facilities related to age group differences.

Code	Total Group n = 62(%)	Age 65-74 n = 25(%)	Age 75+ n = 37(%)
No	37 (60)	10 (40)	27 (74)
Yes	8 (13)	3 (12)	5 (13)
NA	17 (27)	12 (48)	5 (13)

Item 4. Explanation of test procedures related to age group differences.

Code	Total Group n = 62(%)	Age 65-74 n = 25(%)	Age 75+ n = 37(%)
No	7 (11)	0 (0)	7 (19)
Yes, some of the time	29 (47)	10 (40)	19 (51)
Yes, most of the time	9 (14)	4 (16)	5 (13)
Yes, all the time	14 (23)	9 (36)	5 (13)
NA	3 (5)	2 (8)	1 (3)

Item 5. Frequency with which nurses introduce themselves related to age group differences.

Code	Total Group n = 62(%)	Age 65-74 n = 25(%)	Age 75+ n = 37(%)
No	0 (0)	0 (0)	0 (0)
Yes, some of the time	14 (23)	3 (12)	11 (30)
Yes, most of the time	21 (34)	11 (44)	10 (27)
Yes, all the time	27 (43)	11 (44)	16 (43)

Item 6. Frequency of nurses addressing patient by their first name without permission.

Code	Total Group n = 62(%)	Age 65-74 n = 25(%)	Age 75+ n = 37(%)
No	31 (50)	16 (64)	15 (41)
Yes, some of the time	9 (15)	2 (8)	7 (19)
Yes, most of the time	13 (21)	3 (12)	10 (27)
Yes, all the time	9 (14)	4 (16)	5 (13)

Item 7. Frequency of nurses addressing patients other than Miss, Mr., or Mrs.

Code	Total Group n = 62(%)	Age 65-74 n = 25(%)	Age 75+ n = 37(%)
No	37 (60)	18 (72)	19 (51)
Yes, some of the time	32 (35)	5 (20)	17 (46)
Yes, most of the time	3 (5)	2 (8)	1 (3)
Yes, all the time	0 (0)	0 (0)	0 (0)

Item 8. Provision of privacy during examination or treatments.

Code	Total Group n = 62(%)	Age 65-74 n = 25(%)	Age 75+ n = 37(%)
No	0 (0)	0 (0)	0 (0)
Yes, some of the time	0 (0)	0 (0)	0 (0)
Yes, most of the time	8 (13)	4 (16)	4 (11)
Yes, all the time	54 (87)	21 (84)	33 (89)

Item 9. Age related differences and inappropriate exposure during bathing, examination, or procedure.

Code	Total Group n = 62(%)	Age 65-74 n = 25(%)	Age 75+ n = 37(%)
No	51 (82)	21 (84)	30 (81)
Yes, some of the time	7 (11)	3 (12)	4 (11)
Yes, most of the time	1 (2)	0 (0)	1 (3)
Yes, all the time	3 (5)	1 (4)	2 (5)

Item 10. Age related differences and opportunity to discuss feelings and concerns with the nurse.

Code	Total Group n = 62(%)	Age 65-74 n = 25(%)	Age 75+ n = 37(%)
No	25 (40)	7 (28)	18 (49)
Yes, some of the time	25 (39)	12 (48)	12 (32)
Yes, most of the time	10 (16)	4 (16)	6 (16)
Yes, all the time	3 (5)	2 (8)	1 (3)

APPENDIX F

Results from Items on Questionnaire Related to Level of Education (Socioeconomic Status) and Dignity and Respect

Item 1. Orientation to the unit related to level of education.

Code	Elementary Education n = 27(%)	Secondary Education n = 35(%)
No	7 (26)	9 (26)
Yes	20 (74)	25 (71)
NA	0 (0)	1 (3)

Item 2. Introduction to roommates related to level of education.

Code	Elementary Education n = 27(%)	Secondary Education n = 35(%)
No	15 (67)	16 (46)
Yes	7 (26)	12 (34)
NA	2 (7)	7 (20)

Item 3. Knowledge availability related to level of education.

Code	Elementary Education n = 27(%)	Secondary Education n = 35(%)
No	17 (63)	20 (57)
Yes	5 (19)	3 (9)
NA	5 (18)	12 (34)

Item 4. Explanation of procedures related to level of education.

Code	Elementary Education n = 27(%)	Secondary Education n = 35(%)
No	4 (15)	4 (11)
Yes, some of the time	18 (67)	11 (32)
Yes, most of the time	3 (11)	6 (17)
Yes, all the time	11 (7)	12 (34)
NA	0 (0)	2 (0)

Item 5. Nurses introducing themselves related to level of education.

Code	Elementary Education n = 27(%)	Secondary Education n = 35(%)
No	0 (0)	0 (0)
Yes, some of the time	10 (37)	5 (14)
Yes, most of the time	8 (30)	13 (37)
Yes, all the time	9 (33)	17 (49)

Item 6. Addressing patients by their first name related to level of education.

Code	Elementary Education n = 27(%)	Secondary Education n = 35(%)
No	9 (33)	7 (20)
Yes, some of the time	6 (22)	5 (15)
Yes, most of the time	9 (33)	11 (31)
Yes, all the time	3 (11)	12 (34)

Item 6a.

Code	Elementary n = 27(%)	Secondary n = 27(%)	Post-Secondary n = 8(%)
No	9 (33)	0 (0)	7 (88)
Yes, some of the time	6 (22)	4 (15)	1 (12)
Yes, most of the time	9 (33)	11 (41)	0 (0)
Yes, all the time	3 (11)	12 (44)	0 (0)

Item 7. Addressing patients by names other than Miss, Mr., or Mrs. related to level of education.

Code	Elementary Education n = 27(%)	Secondary Education n = 35(%)
No	15 (56)	22 (63)
Yes, some of the time	12 (44)	10 (28)
Yes, most of the time	0 (0)	3 (9)
Yes, all the time	0 (0)	0 (0)

Item 8. Drawing curtains around patient during examination related to level of education.

Code	Elementary Education n = 27(%)	Secondary Education n = 35(%)
No	0 (0)	0 (0)
Yes, some of the time	0 (0)	0 (0)
Yes, most of the time	5 (19)	3 (9)
Yes, all the time	22 (81)	32 (91)

Item 9. Inappropriate exposure during bath, exam, or procedure related to level of education.

Code	Elementary Education n = 27(%)	Secondary Education n = 35(%)
No	20 (74)	32 (91)
Yes, some of the time	5 (18)	3 (9)
Yes, most of the time	1 (4)	0 (0)
Yes, all the time	1 (4)	0 (0)

Item 10. Opportunity to discuss feelings and concerns with nurse related to level of education.

Code	Elementary Education n = 27(%)	Secondary Education n = 35(%)
No	11 (41)	14 (40)
Yes, some of the time	12 (44)	13 (37)
Yes, most of the time	3 (11)	7 (20)
Yes, all the time	1 (4)	1 (3)