

# THE RIGHT TO GET GOOD NURSING CARE



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ABSTRACT

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The purpose of this thesis is to find out nurses' descriptions of the implementation of the act of the patient rights with pulmonary disease in HUS Jorvi hospital and how the nurses implement the act of the patient rights in their own ward.

This thesis aimed at collecting data from nurses at a hospital ward. The research questions are: What are pulmonary patients' rights according to the act described by nurses and how do nurses implement the patient rights in their own ward.

The method of qualitative nursing research was conducted in this thesis. Focus group interviewing was the research method. The informants (n = 5) of this thesis were registered nurses. They worked on a pulmonary ward in HUS Jorvi hospital, Espoo, Finland. The interview was implemented in December 2008. The collected data was analysed by using inductive content analysis. In this thesis the findings propose that the fundamental rights of the patients on pulmonary ward are individuality, co-operation and nursing, which have sub-categories of equality, needs, privacy, information, decision-making, opinions, primary nursing, delicate nursing and specialised nursing. As a uniting category to all these rights was the right to get good nursing care. The implementation of these rights on pulmonary ward complied relatively well with the views of the nurses. There were some challenging situations for instance with the implementation of privacy and confidentiality.

In my opinion and according to the findings the patient rights are very well implemented on the pulmonary ward and the patients are treated equally despite of their origin, race, mother tongue, religion or the nature of the disease.

Key words patient rights, good nursing care

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## 1 INTRODUCTION

The main purpose of this thesis is to find out nurses' descriptions of the implementation of the act of the patient right with pulmonary disease in Helsinki University Hospital Jorvi. Jorvi hospital started in 1976. It was built to be a modern hospital and it was the first central hospital in Finland to treat all kinds of diseases. Jorvi was founded by a group of municipalities of Espoo, Helsingin maalaiskunta, Kauniainen, Kirkkonummi, Vihti and later also Nurmijärvi. Jorvi has always been a congenial place to work at for people with a lot of ideas and good skills. Jorvi hospital was also the first common hospital with a psychiatric department. Jorvi was founded since there was no central hospital in this area – all the needed services were provided only by the Helsinki University Hospital. Jorvi is one of the biggest hospitals in Finland, bigger than most of the central hospitals (Lehtonen 1991, page 7).

In Finland the act on the status and rights of patients was enacted in 1992 and it works as a guideline for nursing professionals where high quality nursing care is provided. After the new legislation patients' rights have been very topical in nursing. The conversation about patients' rights is constant both in newspapers and in nursing journals. For example lack of resources and possible lack of professionals in nursing in the future are factors that have only increased the discussion. People are concerned about their health these days and want to participate in health promotion and rehabilitation more often. People have more knowledge about their rights nowadays compared to the earlier decades.

The Finnish Federation of Nurses, FFN, states in their publication "Ethical guidelines for nurses" (1996) that the nurses' role is to promote and maintain health, prevent illness and alleviate suffering. The individual's values, conviction and manners and his / her right for self-determination are to be respected (for example asthma patient). Pulmonary patients' rights do not differ from general patients' rights. Taking the pulmonary patients' rights into account is an essential part of high quality nursing care. The implementation of the right is a challenge for everyday nursing practise (FFN. 1996).

The theoretical part of this study will focus on the status and rights of patients, care and primary nursing philosophies.

In Finland approximately 5% (250 000) of the population suffers from asthma. Approximately 10% of the population suffers from mild asthma-like symptoms from time to time. According to the World Health Organisation (WHO) approximately 300 million people suffered from asthma and 255 000 people died of asthma in the year 2005. Asthma is the most common disease among children. Asthma is not just health problem for high-income countries, it occurs in all countries regardless of level of development. Over 80% of asthma deaths occur in low- and lower-middle income countries. Asthma deaths will increase by approximately 20% in next 10 years if urgent action is not taken (WHO). Asthma is under-diagnosed and under-treated. Asthma creates a substantial burden to individuals and families and possible restricting individual's activities for a lifetime. (<http://www.who.int/respiratory/asthma/en>)

According to the world health organization (WHO) estimates, 80 million people have moderate to severe COPD. COPD is a chronic obstructive lung disease. More than 3 million people died of COPD in 2005, which corresponds to 5% of all deaths globally. Almost 90% of COPD deaths occur in low- and middle-income countries. At one time COPD was more common for men but because of increased tobacco use among women in high-income countries and the higher risk to indoor air pollution (such as biomass fuel used for cooking and heating) in low-income countries, the disease now affects both men and women almost equally. Total deaths from COPD is estimated to increase by more than 30% in the next 10 years unless urgent action is taken to reduce underlying risk factors, especially tobacco use.

Pulmonary patient in this thesis is any person having pulmonary diseases, age varying from zero to infinite, who is either a patient in an out-patient clinic or a patient admitted to hospital care on pulmonary ward due to his / her illness. The concept pulmonary nursing can be defined as nursing of a patient with pulmonary problems, where diagnosis and treatment of human responses to actual or potential health problems are carried out.

Pulmonary nursing has the goal of promoting the highest possible state of health in each patient.

DNR in this thesis means do not resuscitate. HBM means health belief model.

## 2 EARLIER STUDIES

There are some studies about patients' right in general, more often the research topic is focused to cover one of the rights. Following are a few researches that cover patients' rights in general and after them one study on self-determination, right to good health care and the right to be informed and one example of a research that focuses on a limited patient group.

Juntunen & Leino-Kilpi & Suominen (1994) have studied patients' rights with the purpose of the study to survey nurses' (n = 142) impressions on the implementation of patients' rights in hospital settings. The findings imply that the right to good health care was fulfilled most of all the patients' rights. The right to be informed was seldom implemented. One third of the informants thought that there were defeats in the care of the patients on wards. The right to self-determination was problematic according to 27% of the informants. The management of the patients included defects according to 25% of the informants. The research also revealed that 1% of the informants did not know the act on the status and rights of the patient at all.

Simula (1998) has studied graduating health care students' (n = 280) knowledge and conceptions of the status and rights of patient. The results reveal in short that the students were aware of the patients' rights, wished for more information on them and the implementation in practice. The informants also believed that the patients' rights are implemented poorly. As a development suggestion they named education of future health care professionals.

Lehtonen & Peura (1996) studied patients' right to self-determination, right to freedom, right to be informed and the realisation of nurses' expertise experienced by the patients. The study is an analysis of five topical Finnish Pro gradu-research work from the University of Kuopio. According

to the study findings the right to be informed was actualised well. As long as the information was given in a clear, correct way and was thorough enough it made the patient feel more safe, created believe in recovering, reduced the helplessness, loneliness and fear. The information situation should be secured to be a pleasant moment since when enough time is given to the patient to process information, questions arise and the patient is encouraged to take initiative in their own care. The patients' will and wishes were taken into consideration well. The patients did not on the other hand participate in the care, decision-making nor planning of the care, which was partly seen as a lack of support in self-determination from the nurses.

Noyes (2000) described the views of ventilator-dependant patient (n = 18) who have experienced unnecessary prolongation of caring time in intensive care units. According to the study findings, living in an intensive care unit is unsuitable and harmful to the health and well being of children. The findings describe the experiences of being dependent on a ventilator, the psychosocial impact of the intensive care unit, play and leisure and rehabilitation. Often ventilator-dependent children were considered to have learning difficulties. By themselves they felt they were more disabled by the barriers the society placed in the way of them getting on with their lives. The children are constantly being surrounded by painful procedures, bright lights and sounds and at the same time not being provided with normal contact with their families. The informants described problems like limited intensive care unit bed space and death of other patients. All the informants had limited access to appropriate play and leisure activities. Some of them even had to stay on adult intensive care units where no toys, children's nurses or appropriate soft furnishing occurred. Contacts and communication with peers was also lacking. This study does not suggest any interventions to correct this situation no does it try to explain the reasons why the children were made to stay in intensive care units for unnecessary long periods of time.

These studies have several findings that imply that patient's rights are not always implemented perfectly. On the other hand they indicate that the nurses know the rights of the patient and have visions on them. Perhaps the patient's right should be made more among the patients. In practice it



is relatively difficult to ask for something that one does not know of. Here is a challenge for the nurses to develop the level of information when patient's rights are concerned.

### 3. THEORETICAL FRAMEWORK

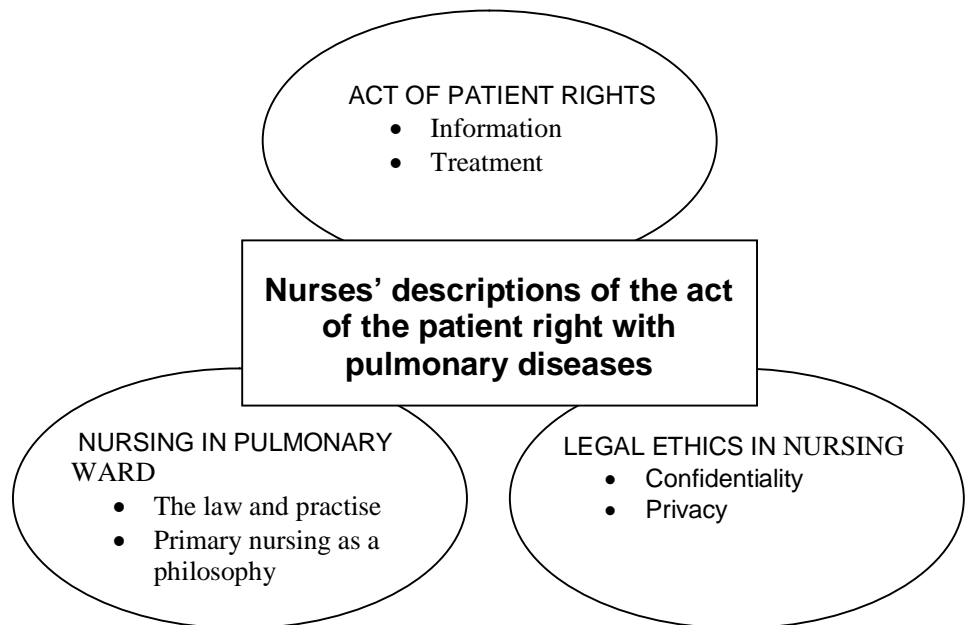


Figure 1 Nurses' description of implementation of the act of the patient right with pulmonary diseases

#### 3.1 Act of patient right

The right to good health care, medical care and related treatment of patients include the promise that the patient has the right to high quality care without human dignity violations and in the manner of respecting his / her privacy, individuality and conviction. The health care should be provided according to the health status and needs of the patient. Access to treatment clause states that in case the treatment, which is considered necessary by a health care professional, is not possible to implement at that moment, the patient has to be asked to wait or has to be taken to treatment to another site of health care. (Act on the status and right of patients 1992).

The clause of emergency treatment considered life-saving treatment to be the most important action, in case patients' will cannot be assessed due

to unconsciousness or any other reason. When the patient has earlier stated clearly his / her will, it should be obeyed under all circumstances. The patients' right to be informed –clause regarded the right to receive information on the state of health, the reasons for the treatment given and any alternative treatment options. Information, which is against the patients' will should not be given to the patient. The patients' right to self-determination issue in the law is stated as follows: The patient has to be cared in mutual understanding with him / her. If the patient refuses a certain treatment of measure he / she has to be cared according to possibilities in another medically accepted way in mutual understanding with him / her. (Act on the status and right of patients, 1992)

The patient documents are to be kept confidential in the health care unit. In case the data of the patient file is to be given to another health care professional in other health care unit, patient written consent should be made. In case the patient is not satisfied with the care he / she has received, the patient has the right to make a complaint. Every health care unit should have a patient ombudsman. The tasks of the patient ombudsman are to inform on the patient's rights, to assist in making complaints and to promote the patient's rights within the health care professionals. (Act on the status and rights of patients 1992)

A patient in the act on the status and rights of patients (1992) is defined as a person using health care services. The concept health care and medical care constituted of the action taken to define, return, or maintain the patient's health. The actions are carried out by professionals in hospitals or health care centres.

A health care professional is a person who is either registered on the basis of the ministry of social and health or acts according to the right by the law (Act on the status and right of patient. 1992)

### 3.2 Patient guidance

Information as a concept has a diversity of meanings from everyday usage to technical settings. In generally speaking, the concept of information is closely related to notions of constraint, communication, control,

data, form, instruction, knowledge, meaning, perception and representation.

Information theory is concerned with the analysis of an entity called "communication". Communication is the process of transferring information from a sender to a receiver with the use of a medium in which the communicated information is understood by both sender and receiver. It is a process that allows organisms to exchange information by several methods. Communication requires that all parties understand a common language that is exchanged.

The internet has already impacted health care with more and more patients becoming well informed about their health concerns. No longer the sole provider of health information, physicians and nurses may need to interpret internet sources of information to patients and their families. Because not all the internet-based information is accurate, nurses need to become information brokers so they can help people to access high-quality, valid websites; interpret the information and then help the patient evaluate the information and determine if it is useful to them. Clark (2000) predicts that the difference between the future novice and expert nurse will be in knowing where to look for information and how to use it.

Telecommunications is the transmission of information from one site to another using equipment to transmit information in the form of signs, signals, words or pictures by cable, radio or other system (Chaffer, 1999. p. 27). Tele-health uses telecommunication technology to provide long-distance health care. It can include using videoconferencing, computers or telephones. Tele-nursing occurs when the nurse delivers care through a telecommunication system. Example of Tele-nursing include the nurse who telephones clients at home to assess their progress or to answer questions and the nurse who participates in a video-teleconference where consultants or experts at various sites discuss a patient's health care plan. Information can also create a good nurse-client relationship. Nurse-client relationships are referred to by some as interpersonal relationships, by others as therapeutic relationships and by yet others as helping relationships. Helping is growth-facilitating process that strives two basic

goals (Egan, 1998): Helps patients manage their problems in living more effectively and develop unused or underused opportunities more fully.

### 3.3 Patient treatment

Treatment in health is therapy that is an act of re-medication of a health problem, which include chemotherapy, counselling, pharmacotherapy or psychotherapy. According to the act on the status and right of patients, the right to good health care, medical care and related treatment of patient include the promise that everybody has the right to high quality care without human dignity violations and in the manner of respecting his / her privacy, individuality and conviction.

Nurses play a major role in helping patients implement healthy behaviours. They help patients monitor health, they supply anticipatory guidance and they impart knowledge about health. Nurses can also reduce barriers to action (e.g. by minimizing inconvenience of discomfort) and can support positive actions. (Kozler 2004). Pender et al. (2002) have modified this health belief model to develop a health-promotion model. According to Pender, HBM explains health-protecting or prevention behaviours but does not emphasize health-promoting behaviours.

Nurses can also enhance adherence. Adherence is the extent to which an individual's behaviour (for example taking medications, following diets or making lifestyle changes) coincides with medical or health advice. Degree of adherence may range from disregarding every aspect of the recommendations to following the total therapeutic plan. There are many reasons why some people adhere and others do not. To enhance adherence, nurses need to ensure that the patient is able to perform the prescribed therapy, understands the necessary instructions, is a willing participant in establishing goals of therapy and values the planned outcomes of behaviour changes. (Kozler 2004)

### 3.4 The law and the practise of the patient rights

The goals can be achieved by taking both family centred care and primary nursing philosophies into consideration. These philosophies guide the actions throughout the nursing practice despite the lung patient's condition.

In the legislation the right to be informed and the powers of a representative of the patient deals with the patient's own developmental level in case it is such, that he / she can make his / her own decisions concerning the treatment. The patient also has the right to prohibit the guardian or another legal representative the access to information on his / her health status.

This clause in the legislation also state, that representative of a minor patient does not have the right to forbid treatment necessary toward off a threat to life or health of the patient. In the status of minor patient clause the patient's own opinion has to be assessed whenever possible considering his / her age and developmental level. If a minor patient can not decide by him- / herself, he / she shall be cared according to the will of his / her guardian or legal representative. (Act on the status and right of patient. 1992)

Nordic Association for the Needs of Sick has published standards for care of hospitalised children. These standards state that children shall not be admitted to hospital care unless it is necessary for the health care of the child. (<http://www.Kolumbus.fi/britta.hiitola/stand.html>)

Home care or out-patient clinic care are the primary options. When it is essential for a child to be hospitalised, parents are encouraged to actively participate in the care. Hospitalised children shall have access to their parents at all times, thus parents shall have free visiting hours and possibility to sleep overnight on the ward. The professional team caring for children with lung problem should be able to answer to the physical, emotional and developmental needs of the children and families.

All information given by the professionals shall be such that children's and parents' age and understanding are taken into consideration. Decisions concerning the health care of the child are made together with the family. Continuity of care, tact and understanding care as well as privacy shall be guaranteed.

The standards set also requirement for the hospital environment on patient ward – full opportunity for play, recreation and education according

to the age and condition of the child shall be provided.

(<http://www.Kolumbus.fi/britta.hiitola/stand.html>)

Lung nurse is involved with the child and family in various aspects like growth and development. The role of the nurse varies with the family's individual needs, but the goal is always to support and increase families' resources and improve the quality of life (FFN. 1996).

A therapeutic relationship is caring, where both the nurse and family have their own separate, clearly defined fields with open two-way communication. The role of the nurse is to provide professional and positive support and to enable the families control over the health care of the sick child. Being a family advocate includes working with the family members and setting the goals together. The nurse should be able to identify the needs of the family and plan interventions accordingly. Nurse advocate assists the family in making informed choices and acting according to the child's best interest (Wong 1995). When the nurse's role is to be a health promoter, he / she acts both to promote health and prevent illness by supporting growth and development and preventing health problems. A health teacher gives information and guidance on disease process and preventing. Counsellor's role is to be an active listener. A nurse coordinator makes sure with the multi-professional team that the nursing services as well as other health care related services function well (Muscarì, 2001).

### 3.5 Primary nursing as a philosophy

Nurses' role is to be the representative of the patient and their family when communicating with the physician and planning the care. The nurse is the one who familiarises herself / himself with the interests and wishes of the patient and gets to know the patient more deeply compared to the other nursing professionals. The primary nurse can see the needs of the patient in advance (Smith 1999).

Primary nursing can be described both as a nursing philosophy and an organisational model. It is a view of nursing where the professionalism and patient-centred aspects are emphasised. In clinical setting primary nursing means the holistic responsibility of patient's care, thus one nurse

is responsible for the care of a hospitalised patient from the admittance to the discharge. Though one nurse is not working 24 hours a day, he / she has the overall responsibility and co-ordination of the planning and implementation of the patient care. As associate primary nurse takes over the responsibilities when the primary nurse is not working (Hegyvary. 1987, Wong. 1995). The purpose of primary nursing is profound commitment to patient accountability. The quality of the care is improved according to patients nursed by primary nursing principles (Laakso & Routasalo 1997). The premise of primary nursing, according to Hegyvary (1987), has four principles: responsibility, autonomy, co-ordination and comprehensive care.

Responsibility is the care of the concept of primary nursing. The primary nurse is responsible to the patient and his / her family, to the co-workers, employer, as well as to his / her profession. In addition he / she is legally responsible for implementing nursing care according to the legislation. Responsibility is related to nursing actions varying from communication to development of nursing care. When acting according to the principle of responsibility, the nurse accepts it, perceives its' meaning and strives towards the best achievable result from patient's point of view (Luotolinna-Lybeck & Leino-Kilpi. 1991).

Autonomy in primary nursing indicates that the nurse has the self-determination right on nursing relates issues. Autonomy in single nursing actions allows interaction and co-operation among the nurses (Hegyvary. 1987). Co-ordination principle demonstrates such planning of the care that patient's needs are constantly taken into account with flexible and appropriate nursing actions. Co-ordination also ensures that the patient is cared with shared nursing care plan and impression of nursing (Hegyvary. 1987, Luotolinna-Lybeck & Leino-Kilpi. 1991).

Basic qualities of co-ordination in primary nursing are coherency and harmony. According to patients, the care is more individualised and holistic with primary nursing compared to task-oriented nursing (Laakso & Routasalo. 1997). For a primary nurse comprehensive care is implementing all the nursing action planned to a patient during a work shift (Luotolinna-Lybeck & Leino-Kilpi. 1991). According to Hegyvary (1987), com-

prehensive care can also be called overall care, which in practice signifies for good patient guidance, emotional support and high quality care (Luotolinna-Lybeck & Leino-Kilpi. 1991).

The philosophy of primary nursing is advisable and significant in nursing since the therapeutically beneficial nurse-patient-relationship, the supportiveness of constant caregiver and the family focus (Wong. 1995). In Pontin's (1999) thorough literature review on primary nursing, he suggests ten elements that are included in the concept of primary nursing – 5 A's and 5 C's that are:

Table 1 The concept of primary nursing

A's	Accountability	Nurse accepts the decisive outcome of his / her actions.
	Advocacy	Nurse represents his / her patient.
	Assertiveness	Nurse manifests relevant feelings and behaviour.
	Authority	Nurse has the right to powers in order to direct others
	Autonomy	Nurse acts self-directively
C's	Collaboration	Nurses share views, skills and abilities as well as knowledge and resources.
	Communication	Nurses interact and share information.
	Commitment	Nurse advocated a certain cause.
	Continuity	Nurse enables continuity of care with his / her actions and supports the continuous process.
	Co-ordination	Nurse organises the care.

The principles of family-centred care and primary nursing are very central in nursing care. These philosophies aim at high quality care that can be



assured by implementing care according to the act on the status and right of patients.

Accountability: According to the Code of Ethics of nurses (ANA 2001), accountability means “answerable to oneself and others for one’s own actions”. It is also the ability and willingness to assume responsibility for one’s actions and to accept the consequences of one’s behaviour. Accountability can be viewed as hierarchic, starting at the individual level, then the institutional or professional level and then the societal level. At the individual or client level accountability is reflected in the nurse’s ethical integrity. At the institutional level it is reflected in the statement of philosophy and objectives of the nursing department and nursing audits. At the professional level it is reflected in standards of practice developed by national or provincial nursing associations. At the societal level it is reflected in legislated nurse practice acts.

Advocacy: A patient advocate acts to protect the patient. In this role the nurse may represent the patient’s needs and wishes to other health professionals, such as relaying the patient’s wishes for information to the physician. They also assist patients in exercising their rights and help them speak up for themselves.

Assertiveness: Nurses assess and diagnose the patient’s actual and potential health problems, plan care and evaluate the patient’s outcomes. Direct personal care activities such as bathing, changing linen, feeding and light housekeeping activities to maintain a clean and safe home environment.

Authority: Authority is defined as the legitimate right to direct the work of others. It is an integral component of managing. Authority is conveyed through leadership actions; it is determined largely by the situation and it is always associated with responsibility and accountability.

Autonomy: A profession is autonomous if it regulates itself and sets standards for its members. Providing autonomy is one of the purposes of a professional association. If nursing is to have professional status, it must function autonomously in the formation of policy and in the control of its activity. To be autonomous a professional group must be granted legal

authority to define the scope of its practice, describe its particular functions and roles and determine its goals and responsibilities in delivery of its services. To practitioners of nursing autonomy means independence at work, responsibility and accountability for one's actions. Autonomy is more easily achieved and maintained from a position of authority.

Collaboration means a collegial working relationship with another health care provider in the provision of patient care. Collaborative practice requires the discussion of patient diagnosis and co-operation in the management and delivery of care. Each collaborator is available to the other for consultation either in person or by communication device, but need not be physically present on the premises at the time the actions are performed.

Communication has various meanings, depending on the context in which it is used. To some communication is the interchange of information between two or more people; in other words the exchange of ideas or thoughts. This kind of communication uses methods such as talking and listening or writing and reading. However painting, dancing and storytelling are also methods of communication. In addition, thoughts are conveyed to others not only by spoken or written words but also by gestures or body actions. Communication may have a more personal connotation than the interchange of ideas or thoughts. It can be a transmission of feelings or a more personal and social interaction between people. Sometimes a nurse is said to be efficient but lacking in something called bedside manner. The intent of any communication is to elicit a response. Thus, communication is a process. It has two main purposes: to influence others and to obtain information. Communication can be described as helpful or unhelpful. The former encourages a sharing of information, thoughts or feelings between two or more people. The latter hinders or blocks the transfer of information and feelings.

Nurses who communicate effectively are better able to collect assessment data, initiate intervention, evaluate outcomes of interventions, initiate change that promotes health and prevent legal problems associated with nursing practice. The communication process is built on a trusting relationship with a patient and support persons. Effective communication is

essential for the establishment of a nurse-patient relationship. Communication can occur on an interpersonal level within a single individual as well as on interpersonal and group levels. Intrapersonal communication is the communication that you have with yourself; another name is self-talk. Both the sender and the receiver of a message usually engage in self-talk. It involves thinking about the message before it is sent, while it is being sent and after it is sent and it occurs constantly. Consequently interpersonal communication can interfere with a person's ability to hear a message as the sender intended.

Commitment: Nurses have willingness to work hard and give their energy and time to their job. They act to protect the patient. They represent the patient's needs and wishes for information to other health care professionals.

Continuity: A major responsibility of the nurse is to ensure continuity of care. Continuity of care is the co-ordination of health care services by health care providers for patient moving from one health care setting to another and between and among health care professionals. Continuity ensures uninterrupted and consistent services for the patient from one level of care to another and when co-ordinated appropriately, it maintains patient focused individualized care and helps optimize the patient's health status.

Co-ordination: Nurse co-ordinates the activities of all other home health team members involved in the patient treatment plan. Co-ordination can occur individually in person or by telephone with a specific team member such as the dietician or respiratory therapist during a team conference where each team member provides information about the patient's health status.

### 3.6 Legal ethics of nursing

Ethics is commonly defined as the philosophical study of right action and wrong action, also known as "morality". Being "philosophical" does not mean that ethics is a study of or concern only to philosophers. Any human being at one point in his / her life has pondered questions of right and wrong. It is helpful for a nurse to understand ethics because nurses en-

counter many of the same ethical problems and questions as any human being. However, beyond that, because of the nature of their work, there are specific moral questions and problems that arise: questions of confidentiality, patient rights, questions of life and death. An understanding of ethics can help a nurse get a clearer view in these difficult cases of the issue at hand (Lachman 2005).

### 3.6.1 Confidentiality

Confidentiality is a situation in which one's information is to be kept secret. Nurses have always had a duty to keep their patients' confidences. In essence, the nurses' duty to maintain confidentiality means that a nurse may not disclose any information revealed by a patient or discovered by a nurse in connection with the treatment of a patient. As it is in the ethical code of nurses, the purpose of a nurse ethical duty to maintain patient's confidentiality is to allow the patient to feel free to make a full and frank disclosure of information to the nurse with the knowledge that the nurse will protect the confidential nature of the information disclosed. Full disclosure enables the nurse to know the conditions of the patient properly and to treat the patient appropriately. In return for the patient's honesty, the nurse generally should not reveal confidential communications of information without the patient's express consent unless it is required to disclose the information by law. A breach of confidentiality is a disclosure to a third party, without the patient consent or court order, of private information that the nurse has learned within the patient – nurse – relationship. Disclosure can be oral or written (Kozier 2004).

### 3.6.2 Privacy

Privacy is the ability of an individual to seclude information about him- / herself. The content and boundaries of what is considered private can differ among cultures and individuals, but share basic common themes. Privacy is sometimes related to anonymity, the wish to remain unnoticed or unidentified in the public. Physical privacy could be defined as preventing intrusions into one's physical space or solitude. Medical privacy, the right to make fundamental medical decisions without governmental coercion or third party review, most widely applied to questions of contraception.

<http://en.wikipedia.org/wiki/Privacy>

Privacy has many sides from maintaining confidentiality and secrecy to physical privacy. The implementation of these characteristics is difficult in the hospital settings. It is obvious that nurses think carefully about these challenges in their daily work but easily realised solutions are hard to find.

The concept “privacy” is used frequently in ordinary language as well as philosophical, political and legal discussions, yet there is no single definition or meaning of the term.

There are several sceptical and critical accounts of privacy. According to one well known argument there is no right to privacy and there is nothing special about privacy, because any interest protected as private can be equally well explained and protected by other interests or rights, most notably rights to property and bodily security (Thomson, 1975). Other critiques argue that privacy interests are not distinctive because the personal interests they protect are economically inefficient (Posner, 1981) or that they are not grounded in any adequate legal doctrine (Bork, 1990).

Some defend privacy as focusing on control over information about oneself (Parent, 1983), while others defend it as a broader concept required for human dignity (Bloustein, 1964), or crucial for intimacy (Gerstein, 1978; Inness, 1992). Other commentators defend privacy as necessary for the development of varied and meaningful interpersonal relationship (Fried, 1970, Rachels, 1975), or as a value that accords us the ability to control the access others have to us (Gavison, 1980; Allen, 1988, Moore, 2003), or as a set of norms necessary not only to control access but also to enhance personal expression and choice (Schoeman, 1992), or some combination of these (Decew, 1997).

Discussion of the concept is complicated by the fact that privacy appears to be something we value to provide a sphere within which we can be free from interference by others.

#### 4 THE PURPOSE OF THE THESIS AND RESEARCH QUESTIONS

The purpose of this thesis is to find out nurses' descriptions of the implementation of patient rights in a hospital ward.

Research questions

- What are the rights of patients' suffering from pulmonary diseases?
- How do nurses implement the act of patient right in their own ward?

## 5 METHODOLOGICAL BACKGROUND

### 5.1 Qualitative approach to nursing research

Qualitative approach to nursing research since qualitative research method is holistic in general and aims in understanding entities or a whole phenomenon. In qualitative research the researcher becomes the instrument of the research (Polit & Hungler 1999). Qualitative research process is a human experience, where the meanings of words are interpreted. Qualitative nursing research focuses on words rather than figures. In qualitative research it is vital for the researcher to realise that experiences rise from unique contexts. (Talbot 1995)

This thesis will describe certain views of certain registered nurses. Since this is a qualitative study the aim is not to be generalised or to be valid in any other environment (Paunonen & Vehviläinen-Julkunen. 1998). In this thesis the thesis design will mature during the thesis itself and some decisions concerning the data collection will be made on the field. This will require flexibility, which will therefore allow me to adjust to new situations and information. It will be important to constantly evaluate the strategies, procedures and data-collection. (Polit & Hungler. 1999)

Scientific discipline or rigour is valued because it is associated with the worth of research outcomes and studies are critiqued as a means of judging rigour. Rigour needs to be defined differently for qualitative research since the desired outcome is different (Burns 1989; Dzurec 1989; Morse 1989).

### 5.2 Method

Kreuger (1988) suggests that focus group interviews were born in the late 1930's by social scientists who had doubts about the accuracy of traditional information gathering methods. Rice expressed concern in 1931 by stating that "a defect of the interview for the purposes of fact-finding in scientific research, then, is that the questioner takes the lead, data ob-

tained from an interview are likely to embody the preconceived ideas of the interviewer as the attitude of the subject interviewed.” (Rice, 1931, p. 561 cited in Kreuger, 1988, p. 18). This led to a more non-directive approach to interviewing where the emphasis was shifted from the interviewer to the interviewee. According to Stewart and Shamdasani (1990), the focused group interview had its origins in the evaluation of audience response to radio programs in 1941 by Robert Merton, a prominent social scientist. Merton applied this technique to the analysis of army training and morale films during World War II. Focus group interviewing today takes on many forms as researchers modify procedures to suit their own needs. Its use in market research aims to gather consumer perceptions and opinions on product characteristics and advertising.

Focus group interviews enable the producers, manufacturers and sellers to understand the thinking of consumers (Kreuger, 1988, p. 20). Merton however feels that this application of focus group research is being misused in that plausible interpretations are taken from group interviews and are treated as being reliably valid (Merton, Fiske & Kendall, 1990, p. xxi). Denzin and Lincoln (1994, p. 365) state that Merton et. al. Coined the term “focus group” in 1956 to apply to a situation in which the interviewer asks group members very specific questions about a topic after considerable research has already been completed. Kreuger defines a focus group as a “carefully planned discussion designed to obtain perception in a defined area of interest in a permissive, non-threatening environment” (1988, p. 18).

### 5.3 Informants

The informants of this thesis were five (5) registered nurses from pulmonary ward in HUS Jorvi hospital.

The sample selection was made as follows: The head nurse had forwarded the task to the ward sister. The ward sister asked particular nurses for an inward meeting to attend my research interviews with their own free will. The selection of informants was based on voluntariness. The sample size selection was made in co-operation with the head nurse of HUS Jorvi hospital pulmonary department and based on qualitative re-

search approach method. The member of informants (n.5) was considered to be sufficient to gain a relatively comprehensive sample.

All the informants were willing to participate in this study and had relatively wide experience of pulmonary nursing. This can be regarded as the sample's strength. The background of the informants was analysed from the returned background information forms in order to give one perspective of the informant's history.

The average age of the informants was 42 years. All the informants were females. The education of the informants was registered nurse. The average working experience of the informants in nursing field was 11 years.

#### 5.4 Arrangements for the interviews

After my thesis plan was accepted in November 2008, the head nurse was contacted in order to receive research permission. An appointment for the meeting was made to the beginning of December 2008 and the thesis plan was delivered to the head nurse in advance to give her time to familiarise herself with the thesis plan. In the meeting the thesis plan was introduced to her and the application for research permission was posted to her. She gave the approval in December 2008.

After I received her permission letter by post, I was able to proceed with my thesis and make the interviews in the ward. The research permission included the information for the participants that the interview will be carried out in the ward in order not to place unnecessary workload for my informants. This has been a topic that is difficult to get informants to participate into. During the meeting the letters for nurses were given to the head nurse to be distributed (app 1).

Prior to the interviews the informants had received the introductory letter including the themes of the interview (app 1 and 3). Also the background information form and informed consent were attached (app 2 and 3). The interview schedule was formed according to the work shifts of the informants. The time of the interview was agreed with the head nurse.



### 5.5 Data collection

Focus group interview was used as a method of this thesis. According to Stewart and Shamdasani 1990 focus groups can be used at any point in a research program. Focus group can be used to obtain general background information about a topic of interest. According to Patton (1990), focus groups interviews are essential in the evaluation process as part of a needs assessment during a program, at the end of the program or months after the completion of a program to gather perceptions on the outcome of the program.

The interview of this thesis was carried out in two hours in December 2008 and it took place in HUS Jorvi hospital lung ward in the premise of the informants'. The ward sister had made the arrangement for appropriate room reservation. The interview took place in a silent place, not in a patient room nor office. All the informants returned the background information forms for further analysis. All the informed consents were received on paper. Every informant was given an advice of preparing for the interview of approximately from half an hour to one-hour duration. The fulfilled duration of the interviews varied from twenty to forty minutes. All the interviews were audio recorded for further analysing. Also some notes were taken to support the audiotapes. The interview was successful in the manner that it was informative and meaningful.

### 5.6 Data analysis

Qualitative content analysis was used to analyse the information. Qualitative content analysis shows conflicting opinions and unsolved issues regarding meaning and use of concepts, procedures and interpretation. In this thesis the analysis was done as follows.

The analysed information was collected by carrying out focus group interview with five (5) informants. The audio taped material was typed within 2 weeks time of the interview. The audio taped material was a bit low quality. It was valuable to write the information down within short time, when the interview was still fresh in memory. The notes also helped in the writing process. After listening and typing, the tape was replayed and some corrections were made. The writing material was printed and read through

several time by active reading (Kyngäs & Vanhanen. 1999). During the reading phase the data analysis developed.

In this thesis the data analysis was performed by inductive content analysis, which is a process of organising the content of the interviews according to the themes that occurred in them. These processes include analysing the manifested content acquired in an objective and systematic way (Kyngäs & Vanhanen. 1999.).

In this thesis the themes were single words and word pairs occurring from the informants responses. They were obtained by simplifying the interview material. After excessive reading the reduction process started by cutting the word-formatted documents. After the themes had been collected the grouping and forming phase were performed. The grouping was done by connecting the related themes together. When the themes had been simplified paper and pencil technique was used to help visualising the process. The themes were group according to their relations to each other. This way the main category and sub-categories were formed. When the grouping was complete all the categories were named with concepts used by the informants. When writing the findings in this thesis, direct loans from the interviews were included to describe the basis of the data analysis. An example of the data analysis includes a description of forming the main-category, individuality. As I read through the interview material several times a clear picture formed in my mind. The themes started to rise from the text, at that time it was possible to start to separate the themes from the interview material.

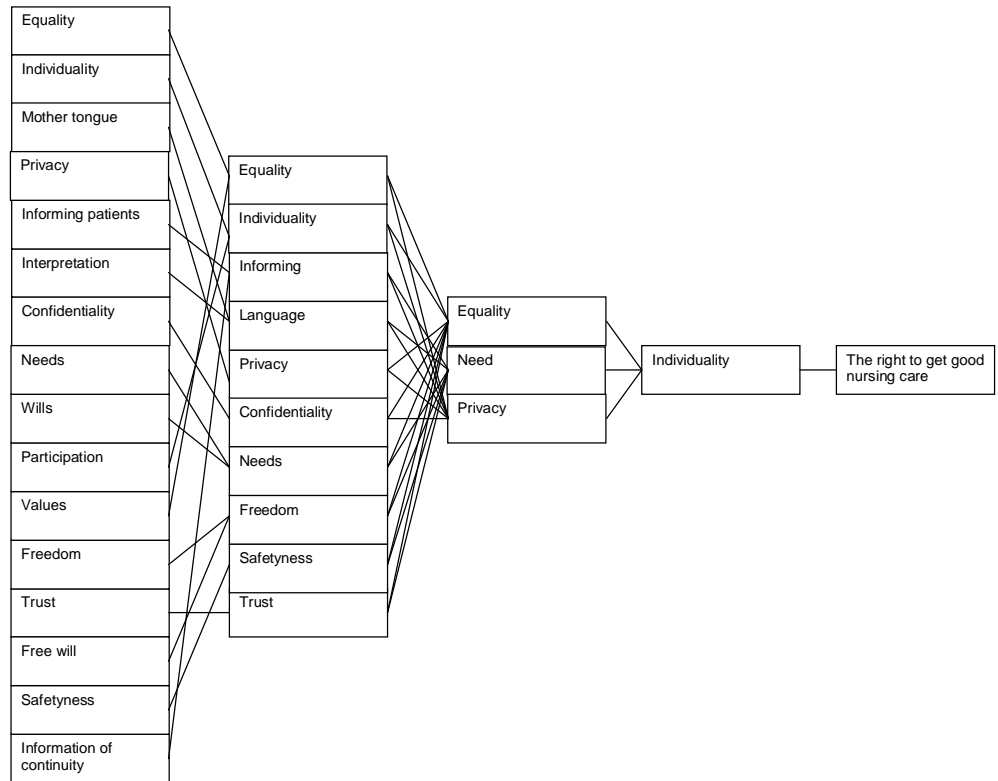


Figure 2 Example of data analysis

Copy and paste image of word was used to create new document that contains only the themes. They were still a big group of words and saying that had to be refined. Implementing the basic needs, care that takes individuality into consideration, equal care despite of the race, mother tongue, origin or religion; taking into consideration the needs, respecting the privacy in care; listening to the wishes of the patient; nurse has the ability to see the of the patient's family.

After grouping these thematically some kinds of expressions I revised the words into somehow associating form and gave the sub-categories descriptive titles: equality, needs and privacy. When the grouping seemed complete, I still read through all the reduced material to make sure that all relevant themes were included in the categorisation. My performance in analysing the data comprehensively can be read in the following section.

## 6 FINDINGS

The material of the interview was many sided. This was due to the fact that all participants had a long working experience and reflected their commitments as informants.

### 6.1 The right to get good nursing care

Most of the informants gave good descriptions of pulmonary patient's rights and their implementation on their ward. But there was also a comment from the informants that shows that fulfilling patient's rights can depend on the patient's condition or on the activity of the patient's family: "If a patient is in good health – also mentally – the patient rights are well implemented. If the patient is very sick or the patient's family and relatives are not active and do not take all the necessary issues into conversation, it is possible that the patient rights are not so well implemented". The informants gave also different information concerning DNR. According to the informants not all the DNR patients are informed that they are DNR cases although all the DNR patients should be informed about that. It is though the doctor's duty to inform that, not the nurse's.

Under is the categorisation as a visual model (figure 1) and later in written form.

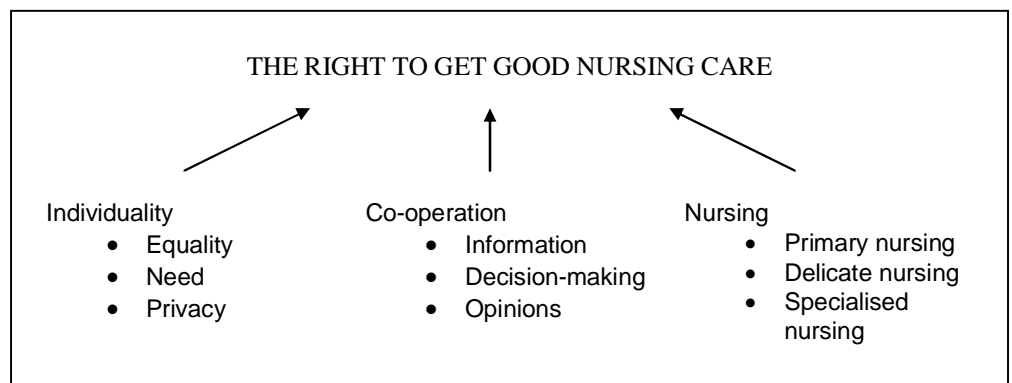


Figure 3 The right to get good nursing care

All the categories were united by a general topic stated by the informants: The right to get good nursing care. It covered all the categories with the sub-categories as well and was very descriptive.

### 6.1.1 Individuality

The first main-category was individuality, which had sub-categories equality, needs and privacy. This category emphasised the importance of individuality and individual care despite the fact that the nursing environment is a hospital, where there were many patients to be cared for.

Equality was seen as a factor that set all the patients to the same level, despite the origin, race, religion or mother tongue of the patient, the same right should be implemented. No racial, financial status or patient activity should make a difference in the way the patient is cared for. It was seen important for the nurses to know from what kind of circumstances the patient comes from in order to understand them better. One descriptive example of equality is the following statement. "Despite the fact where people come from, nowadays there are refugees and immigrants and people who have moved from northern Finland to southern Finland and despite the race, social class or appearance everyone has to have the same right to good health care and treatment." Most of the informants mentioned the language problem as a big issue in the equality. The nurses that do not speak Swedish found it problematic and some of them were willing to study Swedish to be able to give equal services to all the patients. All the patients are not treated in their own mother tongue although that is part of the patient rights. In these cases the informants were concerned if the patient will understand all they try to tell him / her or his / her family. The informants were well aware of patient's right to interpretation but they told that in practice the interpreter is arranged mostly only when the patient is going home to assure that he / she gets the correct information of the home treatment. Lack of time was also mentioned when talking about equality. Some of the informants said that if they are busy, equality is not always fulfilled.

Needs of the patient should be expressed by the patients or their family throughout the hospitalisation. In this way it was possible for nurses to implement them in practice and plan the care so that everything would go according to the needs of the patient. This was a point that the nurses declared to be dependent on the nurse and his / her views. "This always comes from nurses and we do this work with our own personalities. It is

obvious that the personality of the nurse has an effect on how the patient and family are taken into account and how their needs are met. There are so many ways to work, as there are nurses. The real situation has to be emphasised by the nurse's personal views." Some of the informants emphasized the importance of patient's family if the patient is unconscious or not capable to express his / her needs. It is important that the family members are active to make sure that all the patients' needs will be met.

When discussing privacy the nurses valued it but saw it as one of the problematic areas in the realisation of the patient rights. For example the doctor's rounds in big patient rooms were found problematic. Most of the time the doctor's rounds took place on a patient room where there could be four or five patients. When one patient errands were discussed all the others in the room could hear it as well. In this case the professionals did not consider their duty of secrecy. The doctor's rounds were found the biggest problem concerning patient's right to privacy and in the whole interview about patients' rights. "Privacy on doctor's round in big rooms is a problem but patients can say to doctor that they do not want to talk about their problems so that everybody can hear. In these cases patients have had the conversations in doctor's office. But we do not mention to all the patients automatically that they have the right to talk with the doctor outside from the patient room." One of the informants suggested that to improve this situation maybe all the patients could be asked if they prefer the doctor's round conversation in the patient room or in doctor's office and that would be registered in the patient's papers immediately upon his / her arrival and all the staff would then be aware of patient's wish.

### 6.1.2 Co-operation

The second main-category was co-operation including the sub-category of information, decision-making and opinions. The co-operation is seen as a two-way street where on one side are the hospital professionals and the other is the patient and his / her family. The nurses saw this as one of the most important in successful nursing. Information comprehended the right to be informed on the patient's own mother tongue. "What is the nurse's part here is that it is important that the informing happens so, that such a language is used that the patient is able to understand. That the patient understands exactly what it all is about, medical phrases should be

avoided, but simple language, which is understandable to the patient, should be used.”

Basic information such as the reason why the patient is in the hospital and why he / she is treated is essential. Also informing daily on the nurse’s own initiative was emphasized.

One part of information category was the right to have an interpreter. The view of the nurses was that it should be arranged but most of the time family members or relatives are used. “When using relatives to interpret we do not trust 100% that the correct information is given to the patient.”

Decision-making, according to the informants, included the patient as well as the nurse and the physician so the decision-making is co-operational. One of the features in decision-making with the patient was that they might need more time to think over new treatments. Two of the nurses raised one additional aspect to decision-making: “Nowadays patients ask a lot and we expect patients to decide but it is not always like that. Sometimes the physicians make their own decision, which is good for the patient, for example if the patient is unconscious.”

Listening to and asking for the opinions of the patients’ was one sub-category of co-operation. Considering every patient opinion despite his / her age was seen relevant. The nurses brought up the patient ombudsman’s services and the right to appeal as part of the right of the patient.

### 6.1.3 Nursing

The fourth main-category was nursing. It included the sub-categories of primary nursing, delicate nursing and specialised nursing. The primary nurse’s role was to be the representative of the patient and their family when communicating with the physician and planning the nursing care. The primary nurse was the one who familiarised himself with the interests and wishes of the patient and got to know the patient more deeply compared to other nursing professionals. The primary nurse had the ability to see the needs of the patient in advance.

The delicate nursing sub-category was described as considering the cultural and the developmental background from the nursing point of view.

Only the necessary nursing actions were carried out. Delicacy, according to the nurses, was considering the patient's best interest. Avoiding blaming on the patient, even if the reason for the hospitalisation was self-included, was one aspect of this category. "There is for example COPD that is self-caused. He / she has been smoking for many years and has been diagnosed for COPD. And then in the nursing action, the patient is blamed like well, just suffer, you have caused this by yourself. The patient has already a terrible feeling of guilt inside him / her. The feeling of guilt should not be strengthened."

The right to have nurses specialised in lung ward was seen essential. This was one way of making sure that the patient interests are always considered and the needs are met. By having specialised nurses as staff, the right to good health care and the right kind of care are secured according to the nurses.

## 6.2 Nurses' implementation of the act of patient right

The nurses state that they implement patient rights in the hospital ward by treating all the patients equally and individually, by speaking both Finnish and Swedish languages and trying to create privacy for the patients during doctor's rounds and also in other situations. Some of the informants also said that they implement patient rights in their ward by informing the patients about their disease and treatments. Some also state that they implement patient rights in the hospital ward by using an interpreter and by being confidential.

Informants also state that they implement patient rights in hospital ward but it depends on the need and will of the patient. They also state that they implement patient rights by allowing the patients to participate in the nursing care.

The mother tongue and language issue was very clearly one of the biggest worries about patients' rights for equality. Many of the informants felt that their skills in Swedish language are not sufficient. All the informants mentioned the language to be one of the biggest problems when implementing the patient rights. Other big issue was the privacy especially during the doctors' rounds. Most of the informants felt that the patient rights



are not well implemented during the rounds in sense of privacy and confidentiality. All the informants mentioned also that they are willing to give the patient as much information as possible about the disease and inform the patient also about the nursing care plan. Many informants also emphasized that the patients have right to be part of making the decisions of their own treatment and have also right to refuse of the treatment.

Over all the informants implement the patient rights well in their daily work on the lung ward and most of them also think a lot about the issues in implementing the patient rights equally for all the patients.

## 7 DISCUSSION

The main categories of discussions of my thesis are individuality, cooperation and nursing. In this thesis interpretation can be found already in the findings, but I still want to reflect the findings here mainly to discuss the selection and naming the categories. I have described the interpretation of the findings section as follows.

Polit and Hungler 1999 conclude that the findings and interpretations in qualitative studies are often integrated. The uniting category the right to get good nursing care is descriptive and it seems to cover all the other categories. In the thesis findings of Juntunen & Leino-Kilpi & Suominen 1994, the right to good health care was also well implemented. At the beginning it was difficult to name the uniting category, but at one point it came to me, that this sentence was stated by some of the informants and it could offer a good description of all the collected material. Naming the main-categories to answer the research questions seemed difficult but at this point I am satisfied with it.

The informants described the first main-category, individuality, with different words and it was the obvious main-category substance. The sub-categories equality, need and privacy were easily distinguished from the data as they were quite clearly stated. Equality had a very ethical meaning to the informants. The sub-categories needs and privacy were also very important ethical issues to the informants. In the study findings of Lehtonen & Peura 1996, wishes of the patients were considered important. Privacy had many sides from maintaining confidentiality and secrecy

to physical privacy. The implementation of these characteristics was difficult in the hospital settings. It was apparent that the nurses had been thinking carefully about these challenges but still had not found any easily realised solutions.

The second main-category co-operation was difficult for me to name. I still do not know if it is good enough to give possible description, but at least it answers to the research question.

The sub-categories of information, decision-making and opinions were easier to name. Information could have been named informing as well. This sub-category comprehended the right to be informed, as it is about receiving information and it would be the nurse's duty to remind of that. Another challenging character was informing on patients' own language. The informants had been taking care of patients with who they had no common language. According to the informants the help of interpreters was not available often enough. The right to be informed has in the earlier studies indicated contradictory findings. In the findings of Lehtonen's & Peura's 1996, it actualised well, but on the other hand in the study of Juntunen & Leino-Kilpi & Suominen 1999 the findings declare that the right to be informed was seldom implemented. The sub-category – opinions could have been included in the sub-category decision-making, but it was kept separate as it was on the other hand seen as an independent theme.

The third main-category was nursing. The main-category included the sub-categories of primary nursing, delicate nursing and specialised nursing. The primary nurse's role as a representative of the patient was very important to the informants. They described the primary nurse to be the one who implements the rights of the patient to the fullest in the care. The delicate nursing was in connection with the individuality, privacy and equality, but was raised as an independent sub-category under the nursing category as the informants described it also through the nursing actions. The specialised nursing was emphasized by some of the informants. One of the most challenging tasks of the whole learning process was to find informants because this is a topic that many people do not want to talk about, and also to find the most descriptive model of the collected data. It was easy physically but it required a lot of mental capacity

and time to think through the different aspects and possibilities. Now I think that I have created comprehensive findings on the basics of the data analysis. I am pleased with the organisation of the findings. As an overall conclusion of the findings it can be said that the implementation of the rights of the lung patients' rights are the same with the rights in the general level on the ward of my informants.

This subject was very interesting and also difficult since the patients' rights issue is a delicate issue. It has been difficult to find informants for the interviews since this is an issue that many people do not want to talk about. This topic has helped me to widen my knowledge about nursing. It was interesting to find out how well most of the nurses take the patients' rights into consideration in their daily work. The most common problems were language issues and privacy.

It was surprising how all the informants saw the language as one of the biggest problems as well as the privacy problem on doctors' rounds. These two things came clearly out in the results. All the informants agreed about these problems but it was surprising that the informants did not have solutions to solve these problems. With the wide experience that all the informants have from nursing work I would have expected to receive many suggestions to improve the implementation of the patient rights.

In general the patient rights were well implemented according to the informants but there were some exceptions where the informants told that all the patient rights are not necessarily fulfilled. E.g. in some cases the patient is not able to tell his / her own will and wishes and due to this inability the family's role is very important to demand and observe that the patient rights are fully implemented. These kinds of cases need special attention also from the doctors and the nurses. I have a feeling that due to the topic's delicacy not all the informants felt free when participating in the interview. It seems that this topic is more often kept quiet than taken under studies with objective and open mind.

As a conclusion I would say that on the pulmonary ward the patients' rights are very well implemented and the patients are treated equally de-

spite of their origin, race, mother tongue, religion or the nature of the disease.

The made interviews were my first interviews in my life. Interviewing cannot be learned completely by familiarising with literature. Days before the actual interviews I went through an imaginary interview situation to test my interviewing skills. This gave me confidence to proceed to the real interviews. The implementation of the interviews was successful. It was easy to conduct the interview as the informants had prepared well and expressed their thoughts actively. I knew four of the informants beforehand. Despite this fact all the interviews had the same pattern and both the known and unknown informants acted in the same way during the interviews since in the interview situation I was an interviewer but not a nurse or a colleague on the ward.

Writing the interviews open was a time-consuming task to do. I wanted to secure the trustworthiness of this thesis by being very exact in the phase of writing the interviews open. Where the typing was physical, the data analysis required more mental capacity. Inductive content analysis requires critical thinking and consideration of the different possibilities of arranging the data. The data analysis matured during careful reading and thinking. The principle of appropriateness and functionality in this thesis means that informants were willing to participate and able to express themselves and therefore it can be stated, that the research topic was covered as widely as possible (Paunonen & Vehviläinen-Julkunen. 1998). The amount of informants ( $n = 5$ ) pursued to level of good description, therefore the original plan was not changed.

### 7.1 The ethical issues

The ethical issues were easy to handle with the informants. They all were well aware about the ethical issues, e.g. confidentiality and privacy. It seems that professional nurses know the importance of ethical issues and they want to honour the ethical issues in their every day work. They take ethical issues into consideration without problems. It comes naturally in their work and they do not need to pay any extra attention to that. Even all the informants found the privacy to be a problem on doctor's rounds, otherwise they were satisfied to the ethical issues and how they are imple-

mented on their ward. When asking about possible improvements for the doctor's rounds concerning ethical issues it was though surprising how few suggestions they had. Everybody agreed that it is a problem that all other patients in the room hear the conversation between the doctor and the patient but it seemed that nurses are used to the situation and do not pay much attention to that. If nurses or doctor have serious and bad news for the patient, they told that these kinds of news are always told for the patients in a private conversation so that other patients do not hear that.

The informants also emphasized the importance of confidence in that sense that all the information concerning the patients remain in the hospital. They do not talk about these issues outside the hospital when it would be possible that outsiders get the information of some patients.

The informants respected also patients' wishes of privacy if the patients are not willing to let their friends or relatives to know that they are in hospital. Patients have the right to deny giving information even to their closest family members and the informants were well aware of that. That is of course a difficult situation and can course problems for both patient and his / her family members.

## 7.2 The trustworthiness and confidentiality

By securing four aspects, which are credibility, transferability, dependability and conformability the trustworthiness can be secured widely. Credibility includes the aspects of feasible translations and assumptions. Methods for securing the credibility are for example staying in the field, peer debriefing, where a peer tests the researcher, and giving the informants the possibility of reviewing the interpretation and conclusions. The credibility of this thesis was reached by considering the informants' messages carefully and taking straight loans from the interviews to the findings section. The informants of this thesis were registered nurses with high professional ethics and they can be trusted in the sense that they only gave out trustworthy answers. Staying in the field for a long time was not possible in this case, but still the fact that I have completed several clinical placements in the lung nursing, also in the ward of the informants', gives a reflective aspect to the findings. Peer debriefing or giving the informants

the possibility of reviewing the interpretations and conclusions were not used in this thesis due to time limit (comp. Talbot. 1995).

The transferability is meaningful when someone else than the researcher himself determines whether the findings are relevant in another framework. It is secured by presenting wide description and detailed database (comp. Talbot. 1995). In my opinion the transferability of this thesis to any other nursing setting is good when the implementation of the rights is concerned, as also the informants stated, it is dependant on the caregiver.

Dependability means describing the process so logically that any other researcher is able to follow the used method (comp. Talbot. 1995). I think that the thesis method has been described clearly enough for some other researcher to create the same kind of study in any other context. Due to the fact that the thesis method was qualitative the total objectivity is not conceivable in the findings hence the fact that interpretations and conclusions in qualitative study are always personal views of the researcher including his feelings and intuitions have to be accepted. (Paunonen & Vehviläinen-Julkunen. 1998). Conformability assures that the data supports the findings, conclusions and suggestions (comp. Talbot. 1995). The collected data was analysed as carefully as possible with my knowledge and abilities. I find it conformable in the sense that the collected data and findings are in good correlation to each other. The research findings were reported openly and honestly to partly secure the trustworthiness.

The research work is confidential in the sense that the names of the informants will not be published anywhere. The bachelor's thesis will be published in my place of study. Participating in this research as an informant was completely confidential. Neither names nor any other information of the informants, that would reveal them, were published. The research by no means harmed the informants physically, socially or mentally. Participation in this thesis was based on voluntary participation and the informants would have been free to discontinue whenever they wished to do so. The anonymity was also secured in the sense that no particular individual answers were published when there was a risk for one of the informants to be exposed by doing so (Burns & Grove. 1999).

### 7.3 Recommendations for further research

As further research I would recommend a study where the informants will be the patients on lung ward. This would offer a different view on the subject and it would be very interesting to compare that information with the nurse's views. Would there be problems that are common for both patients and the nurses or would the problems be totally different. It would also be possible to conduct a study where the findings of this thesis would be compared with the views of families. It would also be feasible to study doctors' or other staff's views on patients' rights on lung ward. This would cover the multi-professional aspect of nursing and the findings could be also compared with my findings.

It would be also interesting to conduct a study which would research the possibilities to ask patients' opinion about the doctors rounds when they are taken to hospital / upon registration and then follow their wishes to have the talk in a patient room or in private place. How much more time it would take? How much would it cause extra costs considering the extra time and staff needed for it? How much more staff would be needed to take the patients from the patient room to doctor's office?

As further research I would also recommend a study were the views of nurses that have long working experience and nurses that have only 1-2 years of working experience would be compared. What is the effect of long or short working history when implementing the patient rights? It might be interesting to know how long working history changes the views.

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## LETTER FOR NURSES

K. Babone

16.06.2008

To whom it may concern

Dear recipient,

I am studying at Laurea University of Applied Sciences, Espoo Institute Otaniemi and I will graduate in December 2008. As part of my studies I am now doing my final thesis. It is a qualitative nursing research of patient's rights. The purpose of this thesis is to find out nurses' description of implementation of the act of the patient right with lung disease in HUS Jorvi hospital ward. The nature of the interview will be focus group interview.

I would kindly ask for your help in the implementation face of the interview i.e. I would like to ask you to be one of my informants. My plan is to have five informants all together.

The interview will be done in a venue and time suitable for you. The interview session will be tape-recorded.

All the information you give me during the interview will be confidential. I will by no means jeopardise my informants' anonymity. All the collected material will be appropriately destroyed after the research is accepted.

Please contact me for any further information. Thank you in advance for your co-operation.

With kind regards

Kofi Babone  
Nursing student

K. Babone

16.06.2008

**INFORMED CONSENT OF THE INFORMANT**

By signing this informed consent document I state that I know the purpose and other background of the thesis: Nurses' description of implementation of the act of the patient right with lung disease in HUS Jorvi hospital ward.

I am free to discontinue being an informant at any point and I am participating this study of my own free will.

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Date and place

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Signature

K. Babone  
16.06.2008

## RESEARCH THEMES AND BACKGROUND

### Information of the informants

The research themes of the thesis: Nurses' description of implementation of the act of the patient right with lung disease in HUS Jorvi hospital ward are as follows:

1. What are the lung patients rights according to the act of patient right?
2. How do you implement the act of patient right in your own words?

I would like to have some background information of you, which would be necessary for my data analysis.

Please fill in these prior to the interview.

Your age \_\_\_\_\_

Education \_\_\_\_\_

Year of graduation \_\_\_\_\_

Working experience in nursing (years) \_\_\_\_\_

Working experience in lung wards \_\_\_\_\_

## LETTER OF PERMISSION

K. Babone  
16.06.2008

Dear recipient,

I am studying at Laurea University of Applied Sciences, Espoo Institute Otaniemi and I will graduate in December 2008. As part of my studies I am now doing my final thesis. It is a qualitative nursing research of patient's rights. The purpose of this thesis is to find out nurses' description of implementation of the act of the patient right with lung disease in HUS Jorvi hospital ward.

The role of this thesis in Kolmiosairaala project is that it will help to improve the nurse's knowledge of patient right in future in Kolmiosairaala.

The theoretical basis and the key concept of this thesis are:

- The act of the patient right
- Individuality
- Nurses as caregivers

The method of this thesis will be qualitative research method.

The research questions of this thesis are:

- What are lung patient's right according to the act described by nurses?
- How do nurses implement the act of patient right in their own ward?

This thesis will help me to grow professionally. It is going to increase my knowledge about patient right. I will start my thesis work as soon as my study plan is accepted. I am fully aware of being under the oath of confidentiality as the legislation in Finland is prescribed. No information will be released without prior knowledge of informed consent of the participant. I assure to keep any personal information confidential. I will take good care of the data that I will get and not give it to any outside person. I will obey the confidentiality and truthfulness in gathering and analysing the data. I will take care that the thesis will not make any harm to the participants.

In my action, I adhere to Laurea code of research ethics. I welcome the working life partner to be a facilitator of my thesis. I hope my thesis supervisors are going to guide me through out my thesis work.

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Date and place

Signatures:

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Student

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Supervisor

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Working life partner

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