

Development, reliability and validity of the Nurses' Ethical Behaviours for Protecting Patient Rights Scale

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Abstract

Aim: The aim of this study was to develop a self-assessment scale for nurses' ethical behaviours for protecting patients' rights and to determine its reliability and validity.

Methods: This was a methodological study. This study was conducted in public, private and university hospitals in Turkey between August 2018 and May 2019. The sample group consisted of 450 nurses. The item pool was formed with 44 items. After five experts' assessment for content validity, the draft scale was formed with 37 items with a 5-point Likert-type scale. The item-total score correlation and exploratory factor analysis were used.

Results: The scale included 28 items and five subscales (respect for right to information and decision making, providing fair care, providing benefit-not harming, respect for patient values and choices, attention to privacy). Cronbach's alpha was 0.84 for the whole scale.

Conclusion: Validity and reliability have been demonstrated for a newly developed scale to measure nurses' ethical behaviours to protect patients' rights.

KEYWORDS

ethical behaviours, instrument development, nursing, patients' rights, reliability, validity

Summary statement

What is already known about this topic?

- Valid and reliable measurement tools can provide nurses with data on the extent to which nurses internalize the information they have acquired to protect patients' rights.
- No scale has yet been developed to determine nurses' behaviours to protect patients' rights.

What this paper adds?

- The Nurses' Ethical Behaviours for Protecting Patients' Rights Scale is a valid and reliable data collection tool.
- Nurses' ethical behaviours for protecting patients' rights can now be measured with a valid and reliable tool.

The implications of this paper

- The Nurses' Ethical Behaviours for Protecting Patients' Rights Scale could play guiding role in organizing activities for determining and developing nurses' behaviours for protecting patients' rights.

1 | INTRODUCTION

Human rights are the rights that every person has, which must be protected and recognized, and are inalienable and non-assignable. Patients' rights that individuals who demand healthcare have just because they are human and are guaranteed by national and international legislation are the reflection of human rights in patient care environments (Beauchamp & Childress, 2019; Karabulut, 2019; Post, 2004). Many internal and external risks such as diseases and inadequacy of patients, lack of sufficient defence forces, lack of sufficient information about the disease, care and treatment of the disease and complexity of healthcare services threaten patients' rights at different levels (Davoodvand et al., 2016). Nurses accept and undertake patient advocacy as part of their professional identity. Patient advocacy is the duty of a person or group to protect and develop the rights of that patient upon the appointment of the patient (Masic & Izetbegovic, 2014). The main responsibilities of nurses in patient advocacy include knowing and protecting patients' rights and preventing violations of patients' rights (American Nurses Association, 2015; International Council of Nurses (ICN), 2012; Turkish Nurses Association (Türk Hemşireler Derneği), 2009).

Nurses providing care by knowing the patient's rights directly affect patients' lives and quality of life. Nurses have different levels of knowledge, attitudes and awareness regarding patients' rights. For example, Nejad et al. (2011) reported that more than half of the nurses had sufficient knowledge on patients' rights (58.3%), whereas Kavak et al. (2014) reported that 35.7% of nurses did not have sufficient knowledge, which might lead to the violation of patients' rights. As can be understood from the literature and clinical experience, it is necessary to assess nurses' ethical behaviours for protecting patients' rights.

Factors such as the decisions taken by nurses about patients, practices performed on patients that affect their lives and the distribution of limited care resources among patients can lead to violations of patients' rights and ethical problems/dilemmas (Dinç, 2009). Nurses experience ethical problems in protecting patients' rights. In Tang et al.'s (2007) study, nurses ($n = 20$) stated that they sometimes felt helpless in protecting patients' rights when the patient's family did not consent to the interventions planned to resuscitate patients. In a study by Davoodvand et al. (2016), nurses ($n = 15$) stated that their colleagues performed care interventions that did not benefit patients, thereby violating patients' rights, and that they experienced dilemmas.

Nurses rely on ethical principles for protecting patients' rights and making ethical decisions (Beauchamp & Childress, 2019; Masic & Izetbegovic, 2014). Regarding ethical decisions in medicine, in 1979,

Tom Beauchamp and James Childress popularized the use of four principles in efforts to resolve ethical issues. The current scale developed by taking the four ethical principles of Beauchamp and Childress: autonomy, non-maleficence, beneficence and justice (Beauchamp & Childress, 2019). The scale will provide nurses with ability to recognize their own attitudes towards protecting patients' rights. It was foreseen that being aware of attitudes towards protecting patients' rights will lead nurses to exhibit professional behaviours regarding protecting patients' rights. There is no assessment tool evaluating the attitudes of nurses as regards protecting patients' rights. Therefore, the authors considered that the development of a valid and reliable scale assessing nurses' ethical behaviours for protecting patients' rights would contribute to nursing science.

2 | METHODS

2.1 | Aim

This study aimed to develop a self-assessment scale for nurses' ethical behaviours for protecting patients' rights and to determine its reliability and validity.

2.2 | Study design and setting

This was a methodological study. Data were collected from the nurses working in public, private, and university hospitals in different cities in Turkey between August 2018 and May 2019.

2.3 | Sample

To perform factor analysis in validity and reliability studies, the sample size should be at least 5–10 times the item size (Bryman & Cramer, 2001; Kline, 1994). In this study, the draft scale consisted of 44 items, and the study sample consisted of 450 nurses. The inclusion criteria of the research are being a nurse who worked in inpatient or outpatient units, who volunteered to participate in the study and who completed the scale. Nurses working in inpatient and outpatient units in different hospitals participated in the study. This study did not select a random sample as we did not intend to generalize at this early stage of instrument development. Snowball sampling, a type of non-random sampling method, was used to reach nurses in different hospitals and different cities in Turkey. Using the snowball sampling

method provides an advantage in terms of establishing relationships with the consulted participants and accessing potential participants in different cities because they have reached a friend, relative or colleague before (Frey, 2018). With snowball sampling, we could reach nurses from different cities and hospitals.

2.4 | Data collecting and measurements

Data were collected by the researchers, two of whom are experts in the fields of nursing ethics, and two have master's degrees in nursing and are closely interested in the fields of ethics. Data were collected by a Descriptive Characteristics Form (five questions on nurses' age, gender, duration of professional experience, etc.) and Nurses' Ethical Behaviours for Protecting Patients' Rights (NEBPPR)—Draft Scale Form delivered as a web-based structured questionnaire. The draft scale form was developed as follows.

2.4.1 | Formation of the item pool

First, the researchers reviewed the literature on patients' rights regulations, ethical principles and nursing codes of ethics (Burkhardt & Nathaniel, 2019; International Council of Nurses (ICN), 2012; Patients' Rights Regulation, 2014; Turkish Nurses Association (Türk Hemşireler Derneği), 2009; Beauchamp & Childress, 2019). Ethical behaviours about protecting patients' rights, comprising in total 44 cognitive, emotional and psychomotor items, were stratified into four subgroups based upon ethics codes of nurses (International Council of Nurses (ICN), 2012; Turkish Nurses Association (Türk Hemşireler Derneği), 2009) and patients' rights (Patients' Rights Regulation, 2014) under the four ethical principles, namely, autonomy, non-maleficence, beneficence and justice, from Beauchamp and Childress (2019). Each statement in the item pool questioned whether the nurses display ethical behaviour regarding protecting patients' rights. Items were scored on a 5-point Likert scale ranging from *never* (1), *rarely* (2), *sometimes* (3), *very often* (4) to *always* (5).

2.4.2 | Content validity

The draft scale form was mailed to five experts in the fields of nursing and ethics to get their feedback on item quality and how well each item reflects the overarching construct. After getting expert opinions, the content validity indices of the items in the draft scale were calculated by the Davis technique (Davis, 1992), scoring each item between a and d ($a = \text{appropriate}$, $b = \text{needs some revision}$, $c = \text{needs major revision}$, $d = \text{inappropriate}$). Following the experts' scoring of the items, content validity index scores were calculated by the Davis technique: The number of experts selecting (a) and (b) was then divided by the number of total experts, yielding a content validity index for each item (Davis, 1992). Having a score of 0.80 or above suggests appropriate content validity for the study (Davis, 1992; Rubio et al., 2003).

Researchers retained 37 items that scored 0.80 and above on the content validity index in the draft scale form and omitted seven items. The scale was revised according to the recommendations of the experts.

2.5 | Data analysis

Expert opinions were evaluated by the Davis technique. Exploratory factor analyses (EFA) using principal component with varimax rotation were used. Bartlett's sphericity test and the Kaiser-Meyer-Olkin (KMO) test were used to assess the adequacy of the data. The internal consistency of the scale was measured, and Cronbach's alpha and item-total correlations were examined to determine the items of the scale. All statistical analyses were performed SPSS (Statistical Package for Social Science) Version 23.0 software package.

2.6 | Ethical consideration

Written approval was obtained from the Gazi University Ethics Boards (June 2018, no. 77082166-604.01.02). The nurses were informed of the aim and method of the study, and their written informed consent was obtained.

3 | RESULTS

3.1 | Sample

The study sample consisted of 450 nurses. The mean age of participants was 33.1, most of whom were female (92.2%), 60.7% had a bachelor degree, 31.6% had work experience less than 5 years, and 41.8% worked in inpatient units.

3.2 | Item analysis of the NEBPPR scale: Examination of item scores and total score correlations

3.2.1 | Construct validity and reliability

First, item-total score correlations of 37 items in the draft scale were examined. Three items with low reliability coefficients ($r < 0.25$) were removed from the draft scale. Analysis continued with 34 items with reliability coefficients between 0.26 and 0.60, which were highly significant ($P < 0.001$).

3.2.2 | EFA

In order to investigate whether the data were suitable for factor analysis, the KMO coefficient and Bartlett sphericity tests were used. The

KMO coefficient was 0.80, and Bartlett's value was $P < 0.001$. The KMO values are considered excellent between 0.90 and 1.00, very good between 0.80 and 0.89, good between 0.70 and 0.79, fair between 0.60 and 0.69, poor between 0.50 and 0.59 and unacceptable below 0.50 (Akgül, 2005; Yaşar, 2014).

Exploratory principal component analysis of factor analysis was used to determine the factorial structure of the scale. In the five-factor construct revealed by EFA, the factor eigenvalues were all above 1.00. Eigenvalues indicate the variance rate explained by each factor and thus determine the number of significant factors. Factor eigenvalues in the five-factor construct were between 1.54 and 6.60, and the five factors explained 43.14% of the total variance. Five items that had article load values under 0.40, and one item loading on more than one factor, were removed from the scale following the factor

analysis. The factor loads of the remaining 28 items in the scale were between 0.44 and 0.81 (Table 1). Accordingly, the first factor was called 'respect for right to information and decision making', the second 'providing fair care', the third 'providing benefit-not harming', the fourth 'respect for patient values and choices', and the fifth 'attention to privacy'.

3.2.3 | Reliability of the scale

According to internal homogeneity reliability, the item-total score correlations of all items were between 0.26 and 0.64 and was positive and statistically highly significant ($P < 0.001$). Item correlations with their subscale scores yielded reliability coefficients that were between

TABLE 1 Results of exploratory factor analysis of the NEBPPR Scale ($n = 225$)

New no	Items	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
1	Item 1	0.44				
2	Item 8	0.66				
3	Item 19	0.70				
4	Item 20	0.52				
5	Item 23	0.72				
6r	Item 25r	0.52				
7	Item 29	0.61				
8	Item 30	0.59				
9	Item 31	0.68				
10r	Item 14r		0.66			
11r	Item 22r		0.72			
12r	Item 24r		0.72			
13r	Item 33r		0.51			
14r	Item 35r		0.63			
15r	Item 36r		0.81			
16	Item 4			0.51		
17	Item 7			0.62		
18	Item 13			0.58		
19	Item 17			0.60		
20	Item 18			0.64		
21	Item 2				0.53	
22	Item 5				0.63	
23	Item 6				0.54	
24	Item 21				0.65	
25	Item 3					0.76
26	Item 11					0.64
27	Item 34					0.48
28	Item 37					0.62
Eigenvalue		6.60	3.00	1.78	1.74	1.54
Variance explained by factors (%)		12.30	9.14	8.22	7.16	6.32
Total variance explained (%)			43.14			
KMO			0.80			
Bartlett's test. sd: 561 (χ^2/p)			2254.30/<0.001			

TABLE 2 Item-total score correlations of the NEBPPR Scale and its subscales ($n = 450$)

Items (28 items)	Item-total		Item-subscale		
	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	
Factor 1. Respect for right to information and decision making					
1	I make the care-related decision with the patient	0.47	<0.001	0.57	<0.001
2	I inform the patient before my professional practices	0.54	<0.001	0.63	<0.001
3	I inform the patients about their rights	0.57	<0.001	0.70	<0.001
4	I respect the patient's right to know the caregiver and health professional that will provide treatment	0.55	<0.001	0.64	<0.001
5	I introduce myself to the patient	0.51	<0.001	0.67	<0.001
6	I think it is not necessary to explain the practices I will perform to the patients who lost their ability to make decisions (unconscious)	0.48	<0.001	0.58	<0.001
7	I receive the patient's consent before performing my professional practices	0.59	<0.001	0.66	<0.001
8	I inform the patient and/or family about the professional practices I will perform for the patient	0.64	<0.001	0.66	<0.001
9	I create an opportunity for the patient to take part in care and treatment decisions	0.61	<0.001	0.71	<0.001
Factor 2. Providing fair care					
10	I provide more attentive care for the patients whose socioeconomic levels are higher	0.26	<0.001	0.67	<0.001
11	I provide more attentive care for the patients whose beliefs are similar/close to mine	0.34	<0.001	0.72	<0.001
12	I refrain from providing care for the patients whose political opinions are different than mine	0.28	<0.001	0.57	<0.001
13	I give priority to the families of health professionals in my professional practices	0.30	<0.001	0.65	<0.001
14	I am curious about the private lives of patients	0.32	<0.001	0.63	<0.001
15	I provide more attentive care for the patients whose values are similar/close to mine	0.41	<0.001	0.71	<0.001
Factor 3. Providing benefit-not harming					
16	I assess my professional practices in terms of the risk of harming the patients	0.37	<0.001	0.64	<0.001
17	I focus on providing benefit to the patient in my professional practices	0.45	<0.001	0.66	<0.001
18	I take precautions against situations that may harm the patient	0.45	<0.001	0.62	<0.001
19	I refrain from professional practices that have the risk of providing more harm than benefit to the patient	0.47	<0.001	0.73	<0.001
20	I refrain from interfering in a patient's private life without medical reason	0.39	<0.001	0.67	<0.001
Factor 4. Respect for patient values and choices					
21	I respect a patient's right to select the caregiver and health professional that will provide care and treatment	0.47	<0.001	0.72	<0.001
22	I perform my professional practices in the framework of respect for the patient's beliefs	0.45	<0.001	0.67	<0.001
23	I respect a patient's right to perform his/her prayers	0.43	<0.001	0.64	<0.001
24	I refrain from performing professional practices refused by the patient	0.38	<0.001	0.69	<0.001
Factor 5. Attention to privacy					
25	I refrain from sharing information related to a patient's private life with others without medical reason	0.45	<0.001	0.71	<0.001

(Continues)

TABLE 2 (Continued)

Items (28 items)		Item-total		Item-subscale	
		<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>
26	I refrain from sharing patient information with the people who are not involved in the care and treatment process	0.44	<0.001	0.71	<0.001
27	I feel uncomfortable when the patient files are in a public place/open to all	0.47	<0.001	0.71	<0.001
28	I receive the patient's consent to get a practice done/watched on the patient with training purposes	0.50	<0.001	0.69	<0.001

TABLE 3 Correlations of the subscale scores of the NEBPPR Scale with total scale scores and Cronbach's alpha values (*n* = 450)

Scale and subscales	Total <i>r</i>	Factor 1 <i>r</i>	Factor 2 <i>r</i>	Factor 3 <i>r</i>	Factor 4 <i>r</i>	Factor 5 <i>r</i>	α
Total	1.00						0.84
Respect for right to information and decision making	0.85*	1.00					0.81
Providing fair care	0.47*	0.12**	1.00				0.72
Providing benefit-not harming	0.64*	0.45*	0.17*	1.00			0.67
Respect for patient values and choices	0.63*	0.45*	0.05***	0.39*	1.00		0.59
Attention to privacy	0.67*	0.47*	0.13**	0.45*	0.41*	1.00	0.63

Note: *r* = Pearson correlation analysis.

P* < 0.00. *P* < 0.01. ****P* > 0.05.

0.57 and 0.73 and were positive and statistically highly significant (*P* < 0.001; Table 2).

The correlations of the subscale scores with the total scale scores yielded correlation coefficients that were between *r* = 0.47 and 0.85 and were positive and statistically highly significant (*P* < 0.001). Cronbach's alpha was 0.84 for the total scale, and the values of the subscales were, respectively, 0.81, 0.72, 0.67, 0.59 and 0.63 (Table 3).

4 | DISCUSSION

4.1 | The structural validity of the scale

Success in predicting individuals' behaviour depends largely on the validity and reliability of the scale (Çokluk et al., 2018). As far as we know, because there is no assessment scale attempting to assess nurses' ethical behaviours for protecting patients' rights, this is the first valid and reliable scale. Likert-type scales, which were developed to measure attitudes and behaviours, are based on the principle of having people give information on how they will act/feel in a certain situation. This study aimed to develop a scale assessing nurses' ethical behaviours for protecting patients' rights and to determine its reliability and validity in order to be able to provide data about nurses' awareness of patients' rights and how nurses behave to protect patients' rights.

First, the KMO value is checked to test the suitability of the data structure in terms of sample size to continue the factor analysis. In this study, the KMO coefficient was 0.80. It is revealed by Bartlett's test of sphericity that the data come from the multivariate normal distribution. In this study, Bartlett's value was *P* < 0.001. This finding

indicated that the sample number was highly suitable for factor analysis and that the correlation matrix of surveyed items was suitable for performing factor analysis (Çokluk et al., 2018).

In the factorial structure of the scale, factor eigenvalues in the five-factor construct were between 1.54 and 6.60, and the five factors explained 43.14% of the total variance. The eigenvalue is the sum of squared loadings for a factor, so as the eigenvalue increases, the variance explained by the factor increases. In general, factors with eigenvalues 1 and above are considered important factors, but this threshold can be increased based on the results of analysis (Yaşlıoğlu, 2017).

Then, the items were evaluated in terms of whether the values of overlap and factor load met the acceptance level. Values above 0.40 are often suggested for factor loads that sufficiently explain the items' correlation with the factors (subscale). In a multi-factor construct, if an item is included in more than one factor with high load values, the difference between the load values of the item should be at least 0.10. An item that has a high load value on more than one factor is defined as an overlapping item and removed from the scale (Çokluk et al., 2018). In this study, five items that had article load values under 0.40, and one item loading on more than one factor, were removed from the scale. Loads of the remaining 28 items were above 0.40 (between 0.40 and 0.81). All these findings are evidence that the scale has a satisfactory level of construct validity.

4.2 | The reliability of the scale

Item analysis applied with 28 items indicated that the reliability coefficients of all items were adequate (*r* = 0.47–0.85). The standard

interpretation is that if the r -value is between 0.0 and 0.24, a real correlation is non-existent or poor; if it is between 0.25 and 0.49, correlation is fair; if it is between 0.50 and 0.74, the correlation is strong; and if it is between 0.75 and 1.00, the correlation is very strong (Aksakoğlu, 2013). The results of the correlations of the subscales with the total scale score showed that subscales were correlated with/contributed to the total score. These results indicate that the items of the scale serve the purpose of measuring the property desired to be measured.

The Cronbach alpha coefficient is a measurement of the internal consistency of the items in the instrument. The Cronbach alpha value of the scale was found to be highly reliable (0.84). When the alpha coefficient is smaller than 0.40, the measurement tool is not reliable; 0.40–0.59 is poorly reliable; 0.60–0.79 is fair reliability; and 0.80–1.00 is highly reliable (Özdamar, 2013). In this study, Cronbach's alpha for the NEBPPR Scale was found to be highly reliable for the whole scale, thus serving as proof of the measurement of nurses' ethical behaviours for protecting patients' rights by the items making up the instrument.

4.3 | Scoring of the scale

All items received a separate score as *never* (1), *rarely* (2), *sometimes* (3), *very often* (4) and *always* (5). In the final version of the scale with 28 items, Items 6, 10, 11, 12, 13, 14 and 15 had reversed coding. The total scores of 28 items varied between 28 and 140, with higher scores indicating more positive ethical behaviours for protecting patients' rights by nurses. The 'Respect for right to information and decision making' dimension consists of nine items, with a score ranging from 9 to 45. The 'Providing fair care' subdimension consists of six items, with a score ranging from 6 to 30. The 'Providing benefit-not harming' subdimension consists of five items, with a score ranging from 5 to 25. The 'Respect for patient values and choices' subdimension consists of four items, with a score ranging from 4 to 20. The 'Attention to privacy' subdimension consists of four items, with a score ranging from 4 to 20.

4.4 | Limitations

This study had several limitations. Problems around predicting human behaviour using a scale generally become compounded when trying to overlay the scale with the function of predicting moral behaviours. The data obtained through the NEBPPR Scale contained only responses from nurses in one country, reflecting their perceptions regarding their ethical behaviours for protecting patients' rights.

5 | CONCLUSIONS

The findings revealed that the NEBPPR Scale is a valid and reliable data collection tool to measure nurses' ethical behaviours for

protecting patients' rights. Valid and reliable measurement tools can provide data on the extent to which nurses who have been educated in defined patients' rights and the behaviours that lead to these rights being protected have internalized this knowledge. These data can serve as a guide in planning activities to develop nurses' ethical behaviours for protecting patients' rights.

We suggest studying the scale in newly graduated nurses, nurses working in different units and nurses working in healthcare institutions with different organizational structures in future studies. Thus, the data provided by the NEBPPR Scale will form the basis for studies that examine different variables that can affect nurses' behaviours for protecting patients' rights. It is very important to increase nurses' awareness of patients' rights and develop their behaviours for protecting patients' rights. In this context, the NEBPPR Scale could play a guiding role in organizing activities for determining and developing nurses' behaviours for protecting patients' rights.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

AUTHORSHIP STATEMENT

GE, EE and ZGB designed the study. GE, EE and ŞG collected the data. ŞG analysed the data. GE, EE, ŞG and ZGB prepared the manuscript. All authors approved the final version for submission.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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