



Knowledge and selected aspects of respecting patients' rights among nursing personnel

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Abstract

Introduction and Objective. Patients' rights are a key component in the quality and safety of care, and define standards for communication, autonomy, privacy, and dignity. The aim of the study is to assess self-reported knowledge and selected attitudes of nursing personnel toward patients' rights, and to determine their associations with age and professional experience.

Materials and Method. A cross-sectional anonymous online survey was conducted from March – October 2025. Of 503 participants, 473 complete questionnaires (94.0%) were included and 30 incomplete forms were excluded. An author-developed adapted 38-item questionnaire was used. Associations were analyzed using the chi-square test and the Kruskal-Wallis test (statistically equivalent to the Mann-Whitney U test for two-group comparisons); significance was set at $p < 0.05$, and effect sizes were assessed using Cramér's V and η^2 .

Results. Longer professional experience was associated with more frequent declared knowledge of the Act on Patients' Rights (89.9% vs. 77.4%; $p < 0.001$), more frequent reporting that newly employed staff received training (79.1% vs. 56.5%; $p < 0.001$), and higher self-rated knowledge. Participants aged >50 years more often declared knowledge of the Act (90.2% vs. 77.7%; $p < 0.001$), reported training of newly employed staff (79.7% vs. 56.9%; $p < 0.001$), and rated their knowledge more highly. Younger participants more often reported responses indicating breaches of confidentiality and more frequent contact with demanding patient attitudes.

Conclusions. Age and professional experience were associated mainly with self-rated knowledge, training experience, and selected practical aspects of patients' rights. The findings indicate a need for systematic training combining legal knowledge with communication, confidentiality, and organizational responsibility.

Key words

age factors, nurses, health knowledge, attitudes, practice, professional competence, patients' rights

INTRODUCTION

Patients' rights are an integral component of quality and safety of care. They include, among others, the right to information, informed consent, privacy, confidentiality, respect for dignity, and access to medical records. In Poland, the fundamental catalogue of patients' rights and key instruments for their protection are set out primarily in the Act on Patients' Rights and the Patient Rights Ombudsman [1], while the protection of these rights is also reinforced by other legal provisions, including criminal law. The latest report of the Patient Rights Ombudsman and the findings of the Supreme Audit Office indicate that violations of these rights remain an important problem in the healthcare system [2, 3].

Nursing personnel, because of their direct and often prolonged contact with patients, play a particular role in

implementing rights related to information, dignity, intimacy, confidentiality, and participation in treatment. Previous studies among healthcare personnel indicate that declared knowledge of patients' rights does not always correspond to their practical application [4–8]. Knowledge and attitudes may be influenced by age, professional experience, training, and the organisational culture of the workplace.

OBJECTIVE

The aim of the study was to assess self-reported knowledge and selected attitudes of nursing personnel toward patients' rights, and to determine associations between age and professional experience and knowledge of the legal framework, self-rated knowledge, training experience, methods of informing patients, perceived responsibility, and selected aspects of the practical implementation of patients' rights. The study assessed self-reported rather than objectively tested legal knowledge.

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MATERIALS AND METHOD

The study had a cross-sectional design and was conducted from March – October 2025 among nursing personnel practising in Poland. Data were collected using an anonymous online questionnaire, and participation was voluntary. The questionnaire was disseminated via the website of the Patient Rights Ombudsman (RPP), and information about the ongoing study was also provided during training sessions on patients’ rights for healthcare system employees conducted by the RPP. Recruitment was open and non-probability in nature. A total of 503 individuals entered the study. Data from 473 fully completed questionnaires were included in the statistical analysis; 30 incomplete questionnaires were excluded.

The questionnaire was developed using the scope and experience of earlier studies on knowledge and respect for patients’ rights among different groups of healthcare personnel [4–8]. With the permission of the authors of the original study, the final author-developed questionnaire was based on the instrument described by Gotlib et al. [8]. It comprised 38 open- and closed-ended items. Seven items concerned socio-demographic and occupational characteristics: gender, age, professional experience, education, place of employment, main place of work, and position. The remaining items addressed knowledge of legal acts regulating patients’ rights, self-rated knowledge, organization of training, methods of informing patients, perceived staff responsibility, and experience of violations of patients’ rights.

The questionnaire was not formally psychometrically validated; therefore, reliability and construct validity were not established, and the results should be interpreted as self-reported and exploratory data. Items concerning knowledge of legal acts were based on declarative yes/no questions (e.g., ‘Are you familiar with the Act?’), rather than test-based items assessing objective knowledge of specific legal provisions. Consequently, knowledge-related outcomes should be interpreted as self-reported rather than objectively assessed legal knowledge.

Microsoft Excel (Microsoft Office) was used for initial data processing, and statistical analyses were performed using Statistica 13.1 PL (license: Jan Kochanowski University in Kielce). Age was divided into ≤50 and >50 years, and professional experience into ≤25 and >25 years. Associations between categorical variables were assessed using the chi-square test of independence. Differences in ordinal variables between the age and experience cohorts were evaluated using the Kruskal-Wallis test (which yields an asymptotic test statistic equivalent to the Mann-Whitney U test for two-sample comparisons). Statistical significance was set at $\alpha = 0.05$. Effect sizes were expressed as Cramér’s V for chi-square tests and eta-squared (η^2) for rank-based analyses. During editorial revision, a post hoc inpatient–outpatient comparison was added. Classification used the predefined response concerning the main place of work. Inpatient care comprised hospital wards (excluding emergency departments), hospital emergency departments and long-term inpatient care facilities; outpatient care comprised primary care, specialist outpatient care and rehabilitation clinics/workshops. Other or mixed settings (n=23), including emergency medical services, were retained in the descriptive characteristics but excluded from the direct comparison. To ensure complete-case comparability, this analysis was limited to age, professional experience and recognition of four principal legal sources, using chi-square tests and Cramér’s V.

The study was conducted in accordance with the Declaration of Helsinki [9]. Before completing the survey, participants received information about the subject and aim of the study, use of the results, voluntary participation, anonymity, and the right to withdraw at any stage, and then provided informed consent to participate. Because the study was anonymous, non-interventional, and questionnaire-based, approval from a Bioethics Committee was not required. The manuscript was prepared in accordance with the STROBE recommendations for observational studies [10]. The study did not constitute a medical experiment within the meaning of Articles 21–29 of the Polish Act on the Professions of Physician and Dentist, as it was an anonymous, non-interventional questionnaire study.

RESULTS

The analysis included 473 nursing personnel. Women constituted 97.5% of the sample (n=461) and men 2.5% (n=12). The small proportion of men reflects their low representation in this occupational group in Poland, estimated at approximately 3.2%. The largest age group was 51–60 years (n=213; 45.0%). Participants aged >50 years accounted for 58.4% (n=276), whereas 41.6% (n=197) were aged ≤50 years. Professional experience >25 years was reported by 287 participants (60.7%), and ≤25 years by 186 (39.3%). Most participants had a Master’s degree (66.8%), worked in a public healthcare entity (72.7%), and held a position involving staff supervision (56.0%) (Tab. 1).

Table 1. Socio-demographic characteristics of the nursing personnel studied (N=473)

Variable	Category	n	%
Gender	Female	461	97.5
	Male	12	2.5
Age	21–30	29	6.1
	31–40	79	16.7
	41–50	89	18.8
	51–60	213	45.0
	≥61	63	13.3
Professional experience	≤25 years	186	39.3
	>25 years	287	60.7
Education	Academic degree or title	11	2.3
	Master’s degree	316	66.8
	Bachelor’s degree	77	16.3
	Secondary/post-secondary	69	14.6
Place of employment	Non-public healthcare entity (‘NZOZ’ in the questionnaire)*	90	19.0
	Independent public healthcare institution (SPZOZ) or other public healthcare provider	344	72.7
	Own professional practice/business	14	3.0
	Other	25	5.3
Main care setting	Inpatient care	348	73.6
	Outpatient care	102	21.6
	Other/mixed setting	23	4.9
Position	Independent position	208	44.0
	Position involving staff supervision	265	56.0

* The term ‘NZOZ’ was used in the questionnaire as a customary label for a non-public entity providing healthcare services. The authors acknowledge that ‘NZOZ’ is no longer a separate legal category under the current Polish Act on Medical Activity

Table 2. Statistically significant differences in patients' rights-related variables by professional experience

Variable / response	≤25 years, n (%)	>25 years, n (%)	Statistic	p	Effect size
Knowledge of the Act – Yes	144 (77.42)	258 (89.90)	$\chi^2=12.81$	<0.001	V=0.165
Training of newly employed staff – Yes	105 (56.45)	227 (79.09)	$\chi^2=27.72$	<0.001	V=0.242
Having read the Act – Yes	167 (89.78)	273 (95.12)	$\chi^2=4.16$	0.041	V=0.094
Knowledge of the Act: low/ very low	11 (5.91)	8 (2.79)	H=26.83	<0.001	$\eta^2=0.065$
Knowledge of the Act: average	114 (61.29)	107 (37.28)	H=26.83	<0.001	$\eta^2=0.065$
Knowledge of the Act: high/ very high	61 (32.80)	172 (59.93)	H=26.83	<0.001	$\eta^2=0.065$
Method of informing: publicly accessible notice board	142 (76.34)	232 (80.84)	$\chi^2=12.27$	0.015	V=0.161
Method of informing: do not know	8 (4.30)	1 (0.35)	$\chi^2=12.27$	0.015	V=0.161
Responsibility: all staff members	121 (65.05)	204 (71.08)	$\chi^2=13.44$	0.020	V=0.169
Responsibility: do not know	15 (8.06)	10 (3.48)	$\chi^2=13.44$	0.020	V=0.169
Self-rated knowledge: average	104 (55.91)	106 (36.93)	H=21.06	<0.001	$\eta^2=0.050$
Self-rated knowledge: high	73 (39.25)	156 (54.36)	H=21.06	<0.001	$\eta^2=0.050$
Self-rated knowledge: very high	2 (1.08)	23 (8.01)	H=21.06	<0.001	$\eta^2=0.050$
Contact with demanding patient attitudes: very often	60 (32.26)	56 (19.51)	H=9.59	0.002	$\eta^2=0.025$
Contact with demanding patient attitudes: very rarely	6 (3.23)	35 (12.20)	H=9.59	0.002	$\eta^2=0.025$

χ^2 : chi-square statistic; H: Kruskal-Wallis test statistic; V: Cramér's V effect size; η^2 : eta-squared effect size; p: two-sided p-value

Declared knowledge of the Act on Patients' Rights and the Patient Rights Ombudsman was significantly higher among participants with >25 years of experience compared to those with ≤25 years (89.9% vs. 77.4%; $\chi^2 = 12.81$; $p < 0.001$; $V = 0.165$). Longer experience was also associated with more frequently declared reading of the Act (95.1% vs. 89.8%; $\chi^2 = 4.16$; $p = 0.041$; $V = 0.094$), and more frequent reporting that newly-employed staff were trained in patients' rights (79.1% vs. 56.5%; $\chi^2 = 27.72$; $p < 0.001$; $V = 0.242$).

Self-rated knowledge of the Act also differed significantly by professional experience ($H = 26.83$; $p < 0.001$; $\eta^2 = 0.065$). High or very high knowledge was reported by 59.9% of participants with >25 years of experience, compared with 32.8% in the ≤25-year group; an average rating predominated in the shorter-experience group (61.3%). Longer experience was also associated with higher overall self-rated knowledge of patients' rights ($H = 21.06$; $p < 0.001$; $\eta^2 = 0.050$).

Professional experience was associated with the method of informing patients ($\chi^2 = 12.27$; $p = 0.015$; $V = 0.161$) and with perceived responsibility for providing information ($\chi^2 = 13.44$; $p = 0.020$; $V = 0.169$). More experienced participants more often indicated that information on patients' rights was displayed on a publicly accessible notice board and that all healthcare personnel were responsible for informing patients. Those with shorter experience more often reported that they did not know who was responsible. Professional experience was also associated with frequency of contact with demanding patient attitudes ($H = 9.59$; $p = 0.002$; $\eta^2 = 0.025$); participants with shorter experience more often selected 'very often'. No significant differences by professional experience were found for several other variables, including knowledge of the Patient Rights Charter, the European Charter of Patients' Rights and the Constitution of the Republic of Poland, participation in classes on patients' rights during education, refusal of healthcare services, witnessing violations, assessment of staff knowledge, overall respect for rights, and selected practices concerning dignity, consent, medical records, and health information ($p > 0.05$) (Tab. 2).

Age was the second variable significantly associated with declared knowledge of the Act. Knowledge was reported by 90.2% of participants aged >50 years and 77.7% of those aged ≤50 years ($\chi^2 = 13.23$; $p < 0.001$; $V = 0.167$). Older participants also more often indicated that newly-employed staff were trained in patients' rights (79.7% vs. 56.9%; $\chi^2 = 31.43$; $p < 0.001$; $V = 0.258$).

Age was associated with self-rated knowledge of the Act ($H = 16.45$; $p < 0.001$; $\eta^2 = 0.039$) and overall self-rated knowledge of patients' rights ($H = 13.46$; $p < 0.001$; $\eta^2 = 0.031$). High or very high knowledge of the Act was reported by 58.7% of participants aged >50 years and 37.6% of those aged ≤50 years. Older participants also more often rated their overall knowledge as high or very high.

Age was additionally associated with assessment of nursing personnel knowledge ($H = 6.53$; $p = 0.011$; $\eta^2 = 0.015$) and declarations concerning confidentiality ($H = 8.99$; $p = 0.003$; $\eta^2 = 0.022$). In the ≤50-year group, 10.7% selected 'rather yes' or 'yes' when asked about a previous breach of confidentiality concerning a patient's health status, compared with 1.4% in the >50-year group. Younger participants also more often reported very frequent or frequent contact with demanding patient attitudes ($H = 11.80$; $p < 0.001$; $\eta^2 = 0.031$). No significant age-related differences were found for knowledge of the Patient Rights Charter, the European Charter of Patients' Rights and the Constitution of the Republic of Poland, participation in education on patients' rights, methods of informing patients, perceived responsibility, refusal of healthcare services, witnessing violations, overall respect for rights, or selected practices concerning consent, medical records, health information, and care for terminally ill patients ($p > 0.05$) (Tab. 3).

In the post hoc care-setting comparison, the proportion of participants aged >50 years did not differ between inpatient and outpatient personnel (59.5% vs 53.9%; $\chi^2=0.79$; $p=0.375$; $V=0.042$), whereas >25 years of professional experience was more common in inpatient care (64.4% vs 51.0%; $\chi^2=5.41$; $p=0.020$; $V=0.110$). Inpatient personnel more often identified the Constitution of the Republic of Poland (35.6% vs 22.5%;

Table 3. Statistically significant differences in patients' rights-related variables by age

Variable / response	≤50 years, n (%)	>50 years, n (%)	Statistic	p	Effect size
Knowledge of the Act – Yes	153 (77.66)	249 (90.22)	$\chi^2=13.23$	<0.001	V=0.167
Training of newly employed staff – Yes	112 (56.85)	220 (79.71)	$\chi^2=31.43$	<0.001	V=0.258
Knowledge of the Act: low/very low	9 (4.57)	10 (3.62)	H=16.45	<0.001	$\eta^2=0.039$
Knowledge of the Act: average	114 (57.87)	104 (37.68)	H=16.45	<0.001	$\eta^2=0.039$
Knowledge of the Act: high/very high	74 (37.56)	162 (58.70)	H=16.45	<0.001	$\eta^2=0.039$
Self-rated knowledge: average	104 (52.79)	104 (37.68)	H=13.46	<0.001	$\eta^2=0.031$
Self-rated knowledge: high	84 (42.64)	146 (52.90)	H=13.46	<0.001	$\eta^2=0.031$
Self-rated knowledge: very high	4 (2.03)	23 (8.33)	H=13.46	<0.001	$\eta^2=0.031$
Assessment of personnel knowledge: low	24 (12.18)	14 (5.07)	H=6.53	0.011	$\eta^2=0.015$
Assessment of personnel knowledge: high	50 (25.38)	86 (31.16)	H=6.53	0.011	$\eta^2=0.015$
Breach of confidentiality: no	109 (55.33)	191 (69.20)	H=8.99	0.003	$\eta^2=0.022$
Breach of confidentiality: rather yes	17 (8.63)	2 (0.72)	H=8.99	0.003	$\eta^2=0.022$
Breach of confidentiality: yes	4 (2.03)	2 (0.72)	H=8.99	0.003	$\eta^2=0.022$
Contact with demanding patient attitudes: very often	60 (30.46)	55 (19.93)	H=11.80	<0.001	$\eta^2=0.031$
Contact with demanding patient attitudes: often	77 (39.09)	88 (31.88)	H=11.80	<0.001	$\eta^2=0.031$
Contact with demanding patient attitudes: rarely	46 (23.35)	88 (31.88)	H=11.80	<0.001	$\eta^2=0.031$

χ^2 : chi-square statistic; H: Kruskal-Wallis test statistic; V: Cramér's V effect size; η^2 : eta-squared effect size; p: two-sided p-value

Table 4. Post hoc comparison of selected characteristics and recognition of legal sources by main care setting

Variable / response	Inpatient care, n (%)	Outpatient care, n (%)	Statistic	p	Effect size
Age >50 years	207 (59.5)	55 (53.9)	$\chi^2=0.79$	0.375	V=0.042
Professional experience >25 years	224 (64.4)	52 (51.0)	$\chi^2=5.41$	0.020	V=0.110
Patient Rights Charter – Yes	132 (37.9)	33 (32.4)	$\chi^2=0.83$	0.362	V=0.043
European Charter of Patients' Rights – Yes	115 (33.0)	29 (28.4)	$\chi^2=0.57$	0.449	V=0.036
Constitution of the Republic of Poland – Yes	124 (35.6)	23 (22.5)	$\chi^2=5.56$	0.018	V=0.111
Act on Patients' Rights and the Patient Rights Ombudsman – Yes	306 (87.9)	76 (74.5)	$\chi^2=10.05$	0.002	V=0.149

$\chi^2=5.56$; $p=0.018$; $V=0.111$) and the Act on Patients' Rights and the Patient Rights Ombudsman (87.9% vs 74.5%; $\chi^2=10.05$; $p=0.002$; $V=0.149$). No significant setting-related differences were found for the Patient Rights Charter or the European Charter of Patients' Rights (Tab. 4).

DISCUSSION

The findings indicate that age and professional experience were associated mainly with declared knowledge of the Act, self-rated knowledge, training experience, and selected organizational aspects of implementing patients' rights. The most pronounced associations concerned training of newly-employed staff (age $V = 0.258$; professional experience $V = 0.242$) and self-rated knowledge of the Act (age $\eta^2 = 0.039$; professional experience $\eta^2 = 0.065$). At the same time, many basic declarations concerning legal sources and practical respect for patients' rights did not differ by age or experience.

These results should be considered in the broader context of healthcare personnel knowledge of patients' rights. Chmielowiec et al. [11] reported that awareness among medical professionals is increasing, although patients' rights are still insufficiently promoted, and perceived knowledge does not always translate into practice. In the study by Al-Saadi et al. [12] involving 1,213 physicians and nurses, awareness of the importance of patients' rights was high, while reported adherence was lower, particularly for the right

to information. This is consistent with the current finding that age and experience differentiated self-rated knowledge and selected organizational aspects more clearly than most declarations concerning practical observance.

A systematic review by Mpouzika et al. [13] showed substantial heterogeneity in nurses' knowledge and its sources, including undergraduate education, in-hospital training, and learning through experience. In some studies, older age and longer professional experience were associated with greater knowledge, but findings were inconsistent. Barati et al. [14] found an association between observance of patients' rights and professional experience, but not age. Sheikhtaheri et al. [15] reported acceptable knowledge and practice and found that longer clinical experience and higher education were associated with greater knowledge. This partly corresponds with the current findings, in which longer experience was associated with declared knowledge of the Act, higher self-rated knowledge, and more frequent reporting of training.

Other studies do not confirm a consistent role of age or professional experience. Mapatunage and Seneviratne [16] found good knowledge in 67.3% of nurses but positive attitudes in only 48.3%; knowledge was not associated with experience but differed by organizational unit. Gurung and Ghimire [17] found no association of knowledge with age, experience, or training, and only 24.6% of participants had adequate knowledge. Alraimi and Shelke [18] likewise reported no age- or experience-related differences, although awareness differed between hospitals. Thus, the influence of

age and experience may depend on sample structure, clinical setting, work organization, and the method used to assess knowledge.

In the current study, training of newly-employed staff was reported more often by participants with >25 years of experience (79.1% vs. 56.5%) and by those aged >50 years (79.7% vs. 56.9%). The importance of education is also supported by studies conducted at different stages of professional preparation. Kupciewicz et al. [19], in a study of 1,002 nursing students in Poland, Spain, and Slovakia, found variation in self-rated knowledge, and emphasized the need for stronger education during academic training. In the intervention study by Ibrahim et al. [20], training on patients' rights improved nurses' knowledge and perceptions, supporting regular educational activities. Fayyad et al. [21] also found that older age and knowledge acquired through continuing education were associated with more positive patient-safety attitudes, while continuing education was linked to better practice.

Professional experience was also associated with methods of informing patients and perceived responsibility for this duty. More experienced participants more often assigned responsibility to the entire healthcare team. Wick and Kolinski [22] emphasized that implementation of patients' rights depends on procedures, organizational culture, supervision, and a clear division of responsibility. Using direct observation, Fouad et al. [23] identified marked differences between two hospitals in compliance with patients' rights, including information, privacy, confidentiality, and participation in decisions. Together with the findings of Al-Saadi et al. [12] and Alraimi and Shelke [18], these observations suggest that practice reflects both staff competence and organizational conditions.

Confidentiality requires particular attention. Responses suggesting a previous breach of confidentiality ('rather yes' or 'yes') were reported by 10.7% of participants aged ≤50 years compared with 1.4% of those aged >50 years. Because these data are self-reported, they do not constitute an objective measure of violations and may reflect differences in understanding confidentiality or willingness to disclose such events. Mpouzika et al. [13] noted that privacy and confidentiality are often among the best recognized rights, although knowledge does not always translate into practice. Ibrahim et al. [24], examining confidentiality in digital care, highlighted the importance of data-protection procedures, access and consent management, and regular staff training. The findings of the current study support including confidentiality in continuing education, regardless of age or experience.

The more frequent identification of the Constitution of the Republic of Poland and the Act on Patients' Rights and the Patient Rights Ombudsman by inpatient personnel may be related to greater exposure to complex clinical situations involving consent, information, confidentiality and documentation, as well as to more formalised institutional procedures and training. This interpretation should, however, be treated cautiously because the study did not directly assess the mechanisms underlying these differences.

The relationship between knowledge and practice is not straightforward. Bagherinia et al. [25] found a positive correlation between awareness of patients' rights and observance of those rights, and an even stronger relationship between professional ethics and observance. Similarly,

Sheikhtaheri et al. [15] showed that acceptable knowledge does not imply full compliance with all rights, while Al-Saadi et al. [12] demonstrated a gap between high awareness and lower adherence. Mapatunage and Seneviratne [16] likewise showed that good knowledge does not necessarily correspond to equally positive attitudes, and Fouad et al. [23] highlighted the importance of institutional conditions. In the current study, younger participants and those with shorter experience more often reported contact with demanding patient attitudes, which may reflect both occupational exposure and differences in interpreting communication situations. The discrepancy between declared knowledge and practical observance of patients' rights may reflect not only individual knowledge but also organizational conditions. High workload, staffing shortages, time pressure, multitasking and insufficient procedural support, may limit the practical application of formally known rights. However, these factors were not directly assessed in the present study, and their relative contribution cannot therefore be determined.

Age- and experience-related associations should not be interpreted as a simple accumulation of knowledge over years of work. They may reflect accumulated clinical experience, repeated exposure to situations requiring interpretation of legal standards, participation in workplace training, and familiarity with local procedures. Because some studies found no direct association between age or experience and knowledge [16–18], higher self-rated knowledge among older and more experienced nursing personnel should not be treated as proof of greater objective knowledge. Mpouzika et al. [13] also noted possible discrepancies between self-assessment and objective knowledge. Periodic competency assessment using case-based or situational tools may therefore be more informative than questions about declared familiarity with regulations alone.

The timing and form of education may also be important. Kupciewicz et al. [19] support clear inclusion of patients' rights in undergraduate education, while the intervention study by Ibrahim et al. [20] indicates that targeted training can improve knowledge and perceptions among practicing staff. Personnel with shorter experience may particularly benefit from practical induction concerning local procedures, patient information, confidentiality, and team responsibility. For more experienced personnel, training should focus on updating legal knowledge, confronting established routines with current standards, and addressing newer issues such as electronic medical records and data protection [21, 24].

Practical implementation of patients' rights should also be viewed as a feature of the care system rather than solely an individual nursing competence. Differences between institutions reported by Fouad et al. [23] and Alraimi and Shelke [18], together with the analysis by Ćwik and Kuliński [22], point to the importance of procedures, supervision, access to training, and managerial support. Educational interventions, therefore, should be combined with procedure audits and regular evaluation of practice [22–24]. Overall, the findings obtained in the presented study and the available literature support a multilevel approach in which education begins during academic training and continues through induction and periodic professional development [13, 19–21], integrating legal knowledge with practical scenarios involving information, informed consent, confidentiality, dignity, documentation, and team responsibility.

Limitations of the study. This study has several limitations inherent to its cross-sectional design, voluntary online recruitment, and potential respondent self-selection. The questionnaire was author-developed and adapted, but not formally psychometrically validated; consequently, the self-reported nature of the data may introduce recall and social desirability biases. Also, the questionnaire did not collect sufficiently detailed information to classify workplaces by hospital level or urban/rural location; consequently, these potential contextual determinants could not be examined.

Furthermore, the strong predominance of women reflects the demographic structure of the nursing profession in Poland, and precludes meaningful comparative analyses by gender. Finally, no formal a priori sample-size calculation was performed. Furthermore, 56.0% of respondents held positions involving staff supervision, which represents a substantial proportion of the study sample and may limit generalizability to the wider nursing workforce. Personnel in supervisory roles may have more frequent exposure to institutional procedures, staff induction, training and legal regulations, potentially contributing to higher reported familiarity with the Act and more frequent reporting of introductory training.

CONCLUSIONS

The findings indicate that self-reported familiarity with patients' rights regulations should not be treated as sufficient evidence of their practical implementation. Effective protection of patients' rights requires systematic education combined with organizational conditions that support application of legal and ethical standards in everyday care. Continuing education should therefore emphasize scenario-based training in communication, informed consent, confidentiality, documentation, and shared clinical responsibility across all career stages. Associations with age and professional experience should be interpreted cautiously in view of the self-reported nature of the assessment and the structure of the study sample.

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