

Patient's Needs from Quality Health Care Dimensions as Ranked by Nurses and Patients

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Abstract: Quality can vary markedly between organizations, It is important that health care organizations define precisely what quality care means to patients as well as health team This paper aimed to compare the ranking of patients' needs for quality health care dimensions by nurses and patients. Each subject of the 150 patients was interviewed and asked to rank each of these needs, also the nurses (n=45) were requested to rank these needs not according to their own priorities, but as they thought the patients would do, by separately answering a questionnaire developed by the researchers based on (Götherström et al., 1995, Farrell, 1991). the results revealed that the patients gives high first priority of care as regard continuity, accessibility, and security (74.0, 70.8, 67.3) while nurses give the priority to security, accessibility, and continuity (86.7, 73.8, 53.3) respectively It is noteworthy that all patients and nurses gives low priority of care as regard integrity (13.3). Overall, no statistically significant difference was found between the ranking of nurses and patients related to the overall quality care dimensions $p=0.861$., It was recommended that hospital administrators and clinicians must identify particular patient' needs as an indicator of patient's satisfactions, and develop interventions to meet those needs and priorities, Further studies are recommended to identify the effect of social determinates of patients on their ranking of needs, the difference between patients needs in critical care settings, and the effect of providing care based on patients' needs on the care cost- effectiveness. [Journal of American Science. 2010;6(9):446-455]. (ISSN: 1545-1003).

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1. Introduction

In these days of increasing complexity of multidisciplinary health services and rapid growth of health care technologies, improvement and assurance of the quality of health care have become an issue of primary concern (Van Campen et al, 1998; Raftopoulos, 2005). Historically, quality has been defined at a clinical level, and involves offering technically competent, effective, safe care that contributes to the client's well-being. Quality of care is a multidimensional issue that may be defined and measured differently, according to stakeholders' priorities (Creel et al, 2002).

The integrated definition of health care quality combines three main elements namely; client, professional and management quality, where health service/system gives patients what they want and need at the lowest cost (Ovretveit, 1993). The quality health care design involves service providers, clients, and managers in a structured process to explicitly identify client needs and design service processes with key features to meet those needs (Blazevska et al.,2004 & Chilgren, 2008).

The health care industry is undergoing a rapid transformation to meet the ever-increasing needs and demands of its patient population. Hospitals are shifting from viewing patients as uneducated and with little health care choice, to recognizing them as consumers have many service

demands and health care choices available (Howard, 2000). To establish quality care system, WHO (2006) suggests that a health system should seek to make improvements in six areas or dimensions of quality. These dimensions require that health care be: effective, efficient, equitable, accessible, acceptable, patient centered, and safe.

Hence, the critical step in providing high quality care and achieving patients' and families' satisfaction is the assessment of patients' needs for care (Yi Wen and Gustafson, 2004). However, no consensus seems to be exist about the meaning and concept of need in health domain (Asadi-Lari et al, 2003). According to Webster's dictionary, a need is "a condition marked by the lack of something requisite". A need has been identified as a gap between real and ideal that is both acknowledged by individual's values and potentially amenable to change (McKillip, 1998; Swist, 2001). Additionally, the term need refers to a deficiency that a person is experiencing at any point in time. It motivates a person to behave in a manner to satisfy the deficiency (Ratzburg, 2001).

Need has a broad spectrum, as the range of human experiences is quite large and it may have a direct effect on satisfaction with care For example, patients may have a need for more or better information on some aspect of health. If this need is

unmet, it may result in dissatisfaction with services (Yi-Wen and Gustafson 2004). Therefore, the challenge is to identify and target patients' genuine needs. Mobilizing resources to meet these needs which would certainly keep patients satisfied with services, and lead to better quality care (Asadi-Lari et al, 2004).

The nursing process provides a framework in which the individualizing needs of the patients and the family are met. The first step in this process is a nursing assessment: the process of collecting data to identify the needs and problems of an individual patient and family. In the assessment process, the nurse collects information from various sources, validates this information, sorts and categorizes data, and summarizes or interprets it. The end product is a nursing diagnosis of patient's need which is a judgment based on sound data and information (Rankin and Stallings, 2001).

A need assessment is an important map to help meeting actual needs. It provides data from the clients themselves. These data help staff to set priorities in caring for those clients to meet their needs (Cooper, 2002). According to McKenzie et al. (2002e), there are two basic ways of examining the needs. The first is through the eyes of the health professionals, which are services needs. It means the needs that health professionals believe the target population must have met in order to resolve a health problem.

While, the second way of examining the needs is through the eyes of those in the target population. Both types of needs are important and both must be identified. Certain needs are basic for all people and require satisfaction accordingly. Such needs are addressed on the basis of priority, meaning that some needs are more pressing than others. Once an essential need is met, a person experiences a need on a higher level (Shannon, 2003).

Numerous quality care dimensions and needs were reported by patients and family members as most important to their experience. Specifically, patients and family members want a healthcare environment that: Facilitates a connection to staff, Is conducive to a sense of well-being, is convenient and accessible, Promotes confidentiality and privacy, is caring of the family, is considerate of impairments, facilitates a connection to the outside world, is safe and secure (Stern et al, 2003). Additionally, users of health care want care that is characterized by respecting a patient's values, preferences and expressed needs; providing information and education; emotional support; involvement of family and friends; continuity and transition; physical comfort; and coordination (Graham, 2001).

Patients nursing care must be based on the assessment of patient's needs. It is obvious that the nurse must be able to identify patients' needs to determine patients' care in addition she/ he must understand which needs take priority (El-Kouly, 1999). Although evidence suggests that patients want health care professionals to ask about their physical and emotional needs, current assessment often takes place in an unsystematic manner and professionals frequently do not capture accurately what patients are trying to tell them (Brown et al, 2001). The finding that some patients and families are unsatisfied with the care received and feel that they are not getting what they need (Farrell and Lewis, 2000).

Significant of the study:

Researchers have reported that patients' judgments of quality care rely on the responsiveness of healthcare providers to patients' unique needs (Atkins et al., 1996). However, it has been observed that the nurses and patients tend to evaluate patients' needs differently. Some studies have shown nurses to overestimate patients' needs concerning physical and emotional needs (Farrell, 1991). Conversely Lauri et al (1997) found nurses to underestimate all patients' needs apart from environmental needs, such as information on hospital process.

Accordingly Understanding the needs, requirements, expectations, preferences, and experiences of patients is essential to high-quality performance in any health service activity, therefore this study is carried out to compare the ranking of patients' needs for quality health care dimensions by nurses and patients

Aim of the study

The aim of this study was to compare the ranking of patients' needs for quality health care dimensions by nurses and patients

Research question

Is there a difference between patients' ranking of needs and nurses' ranking based on their beliefs of how patients rank these needs?

2. Material and Methods

Research design

A cross-sectional comparative design was used in the study.

Setting

The study was conducted at Ain Shams University Hospitals. Three surgical wards and three of the medical wards were chosen randomly for the study. The medical wards selected were caring for patients with general medical conditions.

Subjects

Subjects included nursing staff and patients in the designated settings. A total of 45 nurses were working in the selected wards at the time of the study, and all were invited to participate. During the period of the study, 161 patients were receiving care at the six selected wards. Of these, 158 patients fulfilled the only inclusion criterion of being conscious, and able to answer a short questionnaire, and those constituted the patients study sample. Finally 150 patients completely and fill the study questionnaire.

Tools of data collection

A structured questionnaire was used for data collection; it was constructed by the researchers and translated into Arabic language to identify nine groups of patients needs to quality care dimension. This tool was derived and developed from Götherströmet al., 1995, & Farrell, 1991 in relation to the concept of patients' needs and quality health care among patients and staff, these nine groups were Information, Security, Accessibility, Continuity, Influence and respect, Integrity, Communications with patients and relatives, Basic care and Competent care givers. The tool was developed comprising (27) statements that express these nine groups for example(easy to get in touch with the health services, receive satisfactory information about health status, take part in discussion about planning of care and treatment). The respondent was asked to rank each of these needs a score of 1 for the highest priority, 2 for the middle, and 3 for the lowest priority, then the next three needs and so on. This scoring system was used since ranking all 9 groups at once would have been a too difficult task to be performed by patients. A brief and clear explanation of all needs was given. The tool was self-administered and anonymous, but included data about the type of ward. For patients, it included the gender of the patient. For nurses, it included the age and experience years.

Procedures

A jury from five experts in nursing field tested the content validity of the English version of the tool, as well as the Arabic version after translation. Modification, deletion, and rephrasing were done as requested by experts.

A pilot study was done on 15 patients and 5 nurses from surgical and medical wards. This was of major importance to assess both patients and nurses' understanding of the stated needs, and their relevance to them. It also served to test the feasibility of the ranking of these needs by respondents. The finalized tool was reached based on the pilot study

findings. These patients were not included in the main study sample.

The actual fieldwork started at the beginning of July 2006 and ended of January, 2007, for each ward, one specific day was reserved for performing the study among patients. The ward head nurse asked eligible patients whether they wanted to participate after explanation of the study aim. Verbal and written information were given before obtaining patient's oral consent to participate. The patients who agreed to participate were handled the data collection tool and were asked to rank the groups of needs from one to three based on their own priorities.

For the nurses' part, a list of all nurses was obtained, and all of them were invited to participate in the study. The tool along with an explanation letter was sent to each nurse who was working in the selected wards during the time of the study comprising information about the study and its purpose, and the informed consent form. The nurses were asked to rank these needs not according to their own priorities, but as they thought the patients would do.

Of the 158 patients eligible for inclusion in the study sample, seven declined to participate and one patient at the surgical department returned the form unfilled, giving a response rate 150/158 (94.9%).

As for 62 nurses, 49 agreed to participate, and 45(91.8%) returned validly filled forms. Four questionnaires were not filled in and those particular nurses commented that it was not possible for them to do the rankings in such a general way, and that what the needs should relate to a specific situation.

Ethical considerations

The chief physician of each ward gave the permission to perform the study, and staff members were fully informed about the study aim and procedures. Participation by the patients was requested by a nurse who was not involved in the study, and the investigators were not working in those sections of the hospital. The voluntary nature of participation was stressed, as was confidentiality.

Statistical analysis

Data entry and analysis were done using SPSS 11.0 statistical software package. The frequencies of first priority basic needs were compared using chi-square test. Whenever the expected values in one or more of the cells in a 2x2 tables was less than 5, Fisher exact test was used instead. For comparison of ranking between nurses and patients and between medical and surgical wards, Wilcoxon signed rank test was used. Statistical significance was considered at p-value <0.05.

3. Results

The participating patients were 71 men and 79 women, aged 18-83 years. There were 56 from surgical and 94 from medical wards.

The responding nurses were 27 from surgical and 18 from medical departments. Their age ranged between 22 and 55 years, with mean age 35 years. Their nursing experience ranged between one and 30 years, with mean 14 years.

Table 1 points to highly significant difference between the rankings of patients at medical wards and surgical wards, and also show that the patients in medical wards give high first priority of care as regard continuity (88.3), security (84.0) and accessibility (78.7) and give low priority as regard basic care (4.3), integrity (17.0), on the other hand surgical patient give high priority as regard accessibility and continuity (57.1-50.0) respectively.

Concerning ranking of nurses working in surgical and medical wards, (Table 2) shows agreement in both surgical & medical wards as regard basic care and also shows that the nurses in medical wards give high first priority of care as regard accessibility (94.4), followed by security and continuity (83.3) and give low priority of care as regard influence & respect (5.6). Meanwhile, the nurses in the surgical wards give the high first priority of care as security (88.9) and give low priority of care as regard communication with patients & relatives, influence & respect, and accessibility.

Comparison of the needs to dimensions of quality care ranking of patients and nurses in surgical wards revealed some discrepancies; (Table 3). The nurse give high first priority of care as regard security (88.9) and basic care (59.3), but the patients give high first priority of care as regard accessibility of health care (57.1), so there was a significant difference. On other hand there was no significant difference among nurses and patients as regard communication with patients & relatives (0.0).

Table 4 reveals that the patients and nurses give high first priority as regard continuity (88.3) (83.3) and security (84.0) (83.3) respectively. On the other hand there was a significant difference among patients and nurses in medical wards as regard communication with patients & relatives (23.4) (5.6).

As regard all nurses & all patients in surgical and medical wards (Table 5) shows that there is a significant difference in the rankings of needs by patients and nurses in relation to almost all items except competent care givers and integrity. the patients give high first priority of care as regard continuity, accessibility, and security (74.0, 70.8, 67.3) while nurses give the priority to security, accessibility, and continuity (86.7, 73.8, 53.3)

respectively. It is noteworthy that all patients and nurses give low priority of care as regard integrity (13.3). Overall, no statistically significant difference was found between the ranking of nurses and patients related to the overall quality care dimensions $p=0.861$

4. Discussions

The current challenge is to develop health systems that equitably improve health outcomes, respond to people's genuine demands and are financially fair. Likewise, Glickman et al. (2007) & Lindenauer et al. (2007) reported that, the use of financial incentives to reward measured performance has gained recent enthusiastic support. The results of several recent studies examining the effectiveness of pay for performance in comparison to other quality-improvement activities. Consequently, identifying particular patient needs and develop interventions addressing those needs and priorities, thus enabling hospital administrators and clinicians to improve the services they provide (Grol et al., 1999; Blazevska et al., 2004).

The present study aimed at answering the research question of whether there is a difference between patients' ranking of needs and nurses' ranking based on their beliefs of how patients rank these needs related to quality care dimension. The study findings revealed important differences between patients and nurses' ranking of some individual needs. However, in total, no differences could be demonstrated between the ranking of patients and nurses.

When comparing ranking by patients and nurses, the need for continuity took the first priority by patients, and the third one by nurses. This is in agreement with Pereira and Pearson (2003) who has similarly found that [91.5%] of their study subjects rated continuity of care as very important element to them as patients. This can be interpreted as nurses believe that staff members generally provide care of good quality. Consequently, staff members can be exchanged for one another without any negative consequences for patients, on the other hand, continuity to patients means that they know the caregiver, they know what to expect and they do not have to repeat their symptoms, their needs and their expectations regarding care. Moreover, Krishnan and Rudolf (2007) claimed that continuous care not only increased patient satisfaction but also allowed the doctor to accumulate knowledge that saved time, influenced their use of laboratory tests, and allowed for expectant management,

Conversely, accessibility of care took almost the same second rank by both patients and nurses. This result is in congruent with Grol et al (1999), who mentioned that, there was broad consensus on

the importance of availability and accessibility as aspect of quality care among studied patients in eight countries, which imply that accessibility seems to be largely universal and independent to country, health care system and culture. Meanwhile Laine et al (1996) found significantly difference rating among patients and caregivers in relation to access to health care. This findings in the present study may due to the believe of both patients and nurses that medical examination, treatment, and nursing care should be done without unnecessary waiting for patient (Götherström et al., 1995).

Regarding the element competent caregivers, the study findings revealed that this element was ranked almost the same among patients and nurses. Although this is actually a fundamental need for hospitalized patients, thus being competent comprises many factors such as being good at technical as well as human aspects, and giving correct and optimal care to the individual patient. Both the study subject put it in middle position. The researchers attributed this finding to the concept that it is logical to recruit competent and qualified care givers in university hospitals, so there is no necessary to stress this element as a crucial need. This finding was contradicted with Laine et al (1996) who found that, patients and physicians agreed that clinical skill is the most crucial element of care.

Paradoxically, the basic care was given a higher ranking by nurses compared to patients. The lower ranking by patients could be attributed to that the patients may value highly the care they would like to get and which is not provided, not the care that they are used to obtain (Grol et al., 1999). This is in agreement Vedsted et al(2002), found that patients put less emphasis on technical aspects of care as 'relieve patient symptoms quickly', 'not only cure diseases, but also offer services in order to prevent diseases' this concept may be enclosed with other related needs such as competent care givers. This might explain why patients gave lower ranks to such needs, as they might be covered by a competent caregiver. This could be also applied to nurses' ranking. In this regard, it has been mentioned that if the care provider is competent, he/she can handle all kinds of patients needs. Hence, it is through involved behavior that clinical competence evolves into clinical expertise (Benner, Tanner; Chesla, 1996).

Respect for patients includes: 1) respect for the dignity of the person; 2) confidentiality or the right to determine who has access to one's personal health information; 3) autonomy to participate in choices about one's own health (Blazevska et al., 2004). Concerning the need for influence and respect, another paradox was revealed in the present study, where patients gave this need the fifth rank of

priority, while nurses gave it the seventh rank. This is one of the signs of surrendering self to some extent to caregiver in decision making situations, including information and communication. This is in consistent with El Sayed et al (2006) who found patient's right to make decisions had the lowest mean score of agreement among nurses, physicians and patients themselves. According to (Leatherman (2001). Patient empowerment can improve quality of care. Current researches showing that better-informed patients have better outcomes choose less risky procedures and avoid equivocal treatments.

As regards information, where patients gave this need the sixth rank of priority, while nurses gave it the fourth rank. This might be explained by that patients give more priority to respect and influence in decision making which totally based on communication and information, on the other hand, nurses agree on giving patients information and explanation needed to be aware of their illness but not to the extent that allowed them to take decisions. In agreement with these findings, (Laine et al, 1996) reported that patients and physicians disagreed about the relative importance of effective communication of health-related information. Meanwhile, Grol et al (1999) found that from the aspects that were valued most in the total sample of patients was telling patients all the information they want to know about their illness. on the same line Sainio et al (2001) mentioned that patients defined participation in decision-making in terms of asking questions, obtaining/providing information and choosing from/presenting different alternatives.

Concerning communication, it was given low priority by both patients and nurses. The lower ranking by patients could be attributed to their confusion between communication and basic care, where good communication could imply good care by staff. While nurses ranking may be affected by their shortages and work load, so they think that patients need more time spent in care rather than communication. This is in disagreement with Fakhry(2002) who found that subjects ranked the role as communicator as the third important role of nurse However, in this regard, (Teutsch, 2003) & Liligrimiene & Buciuiniene (2008) stressed that Improvements in provider-patient communication can have a positive influence on health outcomes.

According to the present study findings, significant differences could be detected in the rankings of needs by patients at medical wards and surgical wards in relation to almost all items except competent care givers and integrity. This is contradicted with Grol et al (1999) who found that most of patients have many views in common particularly as far as the communication and

accessibility of care are concerned. Meanwhile, for nurses, accessibility was given higher priority in medical wards. These differences could be attributed to the nature and acuity of illness, as well as the period of stay, which could be longer in medical wards, thus needing more continuity of care.

Limitations of the study

The concept of ranking needs was difficult to grasp by some patients. Some of them mentioned that it was difficult to rank the needs "they are all important", whereas others found it easier, "I can do that easily, and I'll do it quickly." The low response rate on the part of nurses might be explained by the fact that they are exposed to a number of investigations and questionnaires, and there are rather shortages of staff nurses that prevent them to give time to fill the questionnaire.

5. Conclusion and Recommendations

There are some discrepancies between patients' ranking of needs and nurses' ranking based

on their beliefs of how patients rank these needs. While patients give more priority to continuity, accessibility, and security while nurses give the priority to security, accessibility, and continuity. It is noteworthy that all patients and nurses give low priority of care as regard integrity and communication. Overall, no statistically significant difference was found between the ranking of nurses and patients related to the overall quality care dimensions. The results may give direction to policies in general practice, thus enabling hospital administrators and clinicians to identify particular patient's needs as an indicator of patient's satisfactions, and develop interventions to meet those needs and priorities. Further studies to identify the effect of social determinates of patients on their ranking of needs, the difference between patients needs in critical care settings, and the effect of providing care based on patients' needs on the care cost-effectiveness.

Table (1) patient's needs for dimensions of quality health care as ranked by them (n= 150)

	Medicine(n=94)			Surgery (n=56)			Chi-square		
	N	%	Rank	N	%	Rank	X ²	P-value	
Information	38	40.43	6	6	10.71	7	14.945	0.000*	
Security	79	84.04	2	22	39.29	4	31.960	0.000*	
Accessibility	74	78.72	3	32	57.14	1	7.884	0.005*	
Continuity	83	88.30	1	28	50.00	2	26.753	0.000*	
Influence & Respect	55	58.51	4	16	28.57	5	12.618	0.000*	
Integrity	16	17.02	8	4	7.14	8	2.964	0.085	
Communications with patients & relatives	22	23.40	7	0	0.00	9	15.359	0.000*	
Basic care	4	4.26	9	12	21.43	6	10.861	0.001*	
Competent care givers	52	55.32	5	27	48.21	3	0.711	0.399	
Wilcoxon Signed Ranks Test	Z	-0.142							
	P-value	0.887							

Wilcoxon Signed Ranks Test to test the change between medicine and surgery

Chi-square:- to comparison between two groups for each item

Table (2) patient's needs for dimensions of quality health care as ranked by the nurses in the study sample (n= 45)

	Medicine (18)			Surgery (27)			Chi-square	
	N	%	Rank	N	%	Rank	X ²	P-value
Information	10	55.56	4	11	40.74	3	0.952	0.329
Security	15	83.33	2	24	88.89	1	0.288	0.591
Accessibility	17	94.44	1	0	0.00	7	40.982	0.000*
Continuity	15	83.33	3	9	33.33	4	10.848	0.001*
Influence & Respect	1	5.56	8	0	0.00	8	1.534	0.215

Integrity	2	11.11	6	4	14.81	6	0.128	0.720	
Communications with patients & relatives	1	5.56	9	0	0.00	9	1.534	0.215	
Basic care	2	11.11	7	16	59.26	2	10.432	0.001*	
Competent care givers	10	55.56	5	9	33.33	5	2.186	0.139	
Wilcoxon Signed Ranks Test	Z	-0.137							
	P-value	0.891							

Table (3) patient's needs for dimensions of quality health care as ranked by patients and nurses in surgical department

	Patients (56)			Nurses (27)			Chi-square		
	N	%	Rank	N	%	Rank	X ²	P-value	
Information	6	10.71	7	11	40.74	3	10.084	0.001*	
Security	22	39.29	3	24	88.89	1	18.142	0.000*	
Accessibility	32	57.14	1	0	0.00	8	25.109	0.000*	
Continuity	10	17.86	6	2	7.41	6	1.608	0.205	
Influence & Respect	16	28.57	4	0	0.00	9	9.557	0.002*	
Integrity	4	7.14	8	4	14.81	5	1.231	0.267	
Communications with patients & relatives	0	0.00	9	0	0.00	7	-	-	
Basic care	12	21.43	5	16	59.26	2	11.663	0.001*	
Competent care givers	27	48.21	2	9	33.33	4	1.642	0.200	
Wilcoxon Signed Ranks Test	Z	-0.141							
	P-value	0.888							

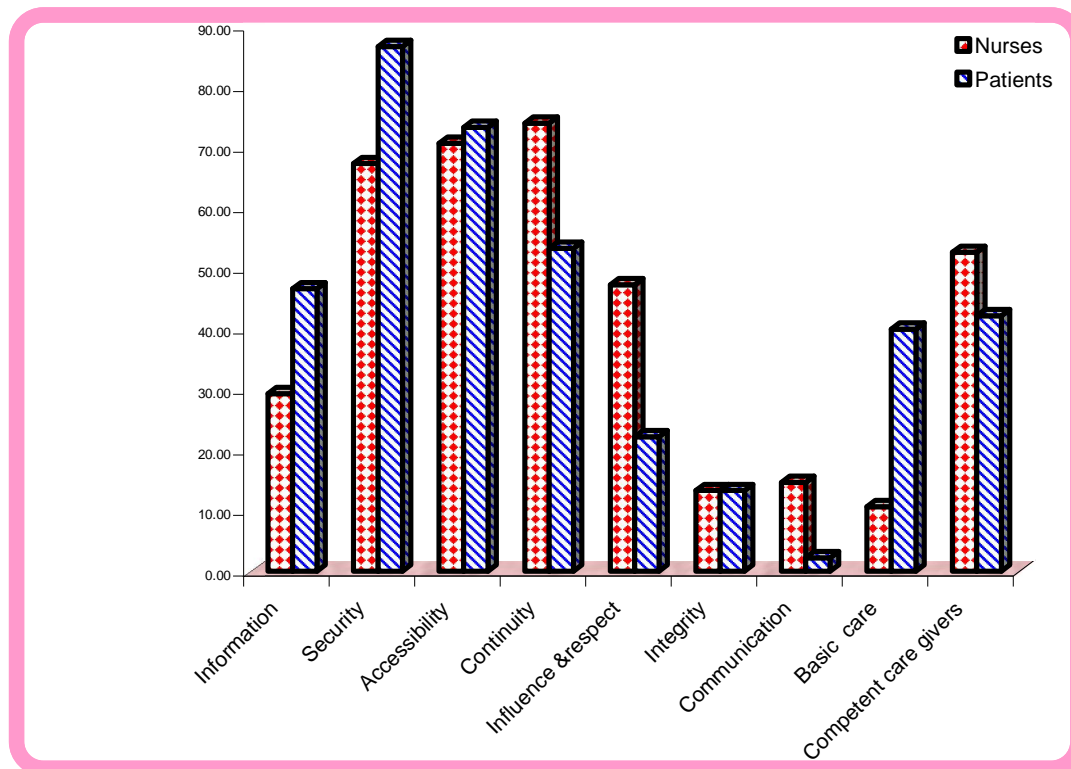
Table (4) patient's needs for of quality health care dimensions as ranked by patients and nurses in medical department

Dimensions	Medical departments							Chi-square	
	Patients (94)			Nurses (18)			X ²	P-value	
	N	%	Rank	N	%	Rank			
Information	38	40.43	6	10	55.56	6	1.412	0.235	
Security	79	84.04	2	15	83.33	3	0.006	0.940	
Accessibility	74	78.72	3	17	94.44	1	2.451	0.117	
Continuity	83	88.30	1	15	83.33	2	0.340	0.560	
Influence & Respect	55	58.51	4	10	55.56	4	0.054	0.816	
Integrity	16	17.02	8	2	11.11	7	0.391	0.532	
Communications with patients & relatives	22	23.40	7	1	5.56	9	2.949	0.086	
Basic care	4	4.26	9	2	11.11	8	1.400	0.237	
Competent care givers	52	55.32	5	10	55.56	5	0.000	0.985	
Wilcoxon Signed Ranks Test	Z	0.000							
	P-value	1.000							

Table (5) patient's needs for quality health care dimensions as ranked by all patients and nurses in the study sample

	All patients N=150			All nurses N=45			Chi-square	
	N	%	Rank	N	%	Rank	X ²	P-value
Information	44	29.33	6	21	46.67	4	4.680	0.031*

Security	101	67.33	3	39	86.67	1	6.389	0.011*	
Accessibility	106	70.67	2	33	73.33	2	0.120	0.729	
Continuity	111	74.00	1	24	53.33	3	6.941	0.008*	
Influence & respect	71	47.33	5	10	22.22	7	8.988	0.003*	
Integrity	20	13.33	8	6	13.33	8	0.000	1.000	
Communication with patients & relatives	22	14.67	7	1	2.22	9	5.153	0.023*	
Basic care	16	10.67	9	18	40.00	6	20.690	0.000*	
Competent care givers	79	52.67	4	19	42.22	5	1.510	0.219	
Wilcoxon Signed Ranks Test	Z	-0.175							
	P-value	0.861							



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