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ΠΕΡΙΛΗΨΗ
Η αξιολόγηση των απόψεων των ασθενών δείχνει στους ασθενείς ότι οι επαγγελματίες υγείας φροντίζουν για την τη συνεχή αξιολόγηση και βελτίωση των υπηρεσιών υγείας. Επίσης δείχνει ότι είμαστε ευσυνείδητοι επαγγελματίας μέσα σε μια γνήσια ανθρωπιστική εργασία. Η παρούσα ανασκόπηση αναλύει τα θεωρητικά και μεθοδολογικά προβλήματα που έχουν προκύψει από τις προσπάθειες να μετρηθεί και να ποσοτικοποιηθεί η νοσηλευτική φροντίδα. Τα αμιγώς αριθμητικά στοιχεία είναι θεωρητικά πιθανό αποστειρώσιμα χωρίς αποκλειστικά διαμετράτηση στις προσωπικές έννοιες. Αφ’ ετέρου οι καθαρώς ποιοτικές μέθοδοι δεν έχουν χρησιμοποιηθεί ευρέως. Η συγκεκριμένη κριτική ανασκόπηση ολοκληρώνεται με τη διατύπωση απλών ερωτήσεων που μπορούν να βοηθήσουν στη διερεύνηση και διατραγματέυση των νοσηλευτικών αναγκών των ασθενών. Δύο απλές ερωτήσεις προτείνεται ως παραδείγματα που θα μπορούσαν να χρησιμοποιηθούν στη καθημερινή κλινική πράξη και προκειμένου να βοηθήσουν τους ηλικιωμένους ασθενείς.

ΛΕΞΕΙΣ - ΚΛΕΙΔΙΑ: Αξιολόγηση, ηλικιωμένοι ασθενείς, νοσηλευτική φροντίδα, ικανοποίηση
ASSESSING SATISFACTION WITH THE NURSING CARE OF OLDER PATIENTS IN HOSPITAL: A DISCUSSION PAPER

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ABSTRACT
Assessing patients’ views indicates to patients that we are concerned about continuous assessment and improving services in general. It also indicates that we are a conscientious professional within a genuine humanistic line of work. The paper discusses the many theoretical and methodological problems that have arisen from attempts to measure and quantify patient satisfaction. Numerical data are thought to be ‘sterile’ without any insight into personal meanings. On the other hand purely qualitative methods have not been widely used. This discussion paper ends with the formulation of two simple questions which can help us to explore and negotiate patients’ needs and satisfaction. Two non-offensive straightforward questions are proposed as examples which could be used on a regular basis by nurses caring for older patients.

KEYWORDS: Assessment, Elderly patients, Nursing care, Satisfaction

INTRODUCTION
Older people’s views of hospitalization and their interaction with health care systems are increasingly important as the proportion of older people in the European Union (E.U.) increases. This is particularly the case in Greece where the percentage of people over 65 years of age in the total population was 26.4% in 2004 and is expected to increase to 39.1% by the year 2030. Today, the projected lifespan at the time of birth is 77.2 for men and 81.9 for women. While the total Greek population in 2004 was 11.041.000 million of whom, 1.971.000 were people over 65 years of age, according to population projections, by the year 2030, the population will be 11.316.000 million of whom 2.780.000 will be over 65 years old (Greek National Statistics Office, 2009).

Recent reforms in the Western world’s health care systems, including the United Kingdom’s National Health Service (NHS), advocate the place of consumer opinion and the provision of a consumer orientated service. Despite the fact patient satisfaction has become an important component of evaluation research many theorists argue that definitive measurements for this concept are elusive.

The present discussion paper covers a time of increasing focus within the NHS on the care of the elderly and increased impetus to improve the quality of care that elder patients receive. Furthermore, current changes in ageing populations will result in a significant increase of those aged 75 years and over within the E.U. and, it is widely acknowledged that a significant number of this population group will suffer some degree of ill health and will attend hospital accordingly (Cipher et al., 2006; Odell et al., 2006). Therefore, research in this area is crucial if appropriate services are to be planned, organised and offered with improved quality of care and realistic costs. The whole situation has been described as the ‘age boom’ primarily caused by post war ‘baby
boomers’ and has implications for the provision of health care. For example, various studies have shown that those over 75 years of age have higher rates of illness, spend more time in hospital, fall more, are more likely to be mentally confused, are more likely to live alone and have more demand for long-term care (Caplan et al., 2005; Mecocci et al., 2005; Cornette et al., 2006).

Furthermore, Mediterranean and many E.U. countries have a large number of general ward hospital beds occupied by elder patients. In many instances the staff may be impatient with these patients as their behaviour can be perceived as “difficult” and/or their care a “heavy task”. There is a bulk of literature to substantiate this observation (Engstrom et al., 2006).

The main objective of this paper is to provide nurses with a simple insight into what makes older people satisfied with their hospital experience. Furthermore, two examples of assessing their satisfaction in a simple but not simplistic mode are suggested. For this purpose a literature search was undertaken using Medline and Cinhal databases in order to identify relevant papers. Key words included satisfaction, elderly patients, nursing care, attitudes, measuring satisfaction, quality of care, and hospitalization. A major limitation of this discussion paper and research on patient satisfaction is that there is no single, objective “gold standard” for measuring and quantifying it. Nevertheless there are recognized methods of conversation analysis which can clarify all issues concerning patient satisfaction.

**Patient satisfaction: the concept**

Patient satisfaction is a quite ambiguous concept because it is claimed that satisfaction can be “measured” though it is not clear what the patient means when he or she states that they are satisfied with something. The greatest difficulty here hinges on the fact that patient satisfaction is a concept and therefore not amenable to direct observation. This implies the necessity of an indicator. A simple example of an indicator might be a smile, a frown or a hand movement which relate theoretically to a state of mood. An indicator has been defined as an observable variable assumed to point to, or estimate some other usually unobservable, variable. The choice of the particular elements in an indicator should be justified by the specification of the theoretical link between the indicators and indicated. In the case of patient satisfaction, the position is not so clear. The difficulty is not related to any shortage of putative indicators but to the absence of their theoretical justification (Langemo et al., 2002; Mueller and Karon, 2004).

Patient satisfaction has been linked directly to quality of care, quality assurance, or even the patients’ self esteem. A more concrete way of describing the links between patient satisfaction in objective terms, includes:

- **structural**, like adequate staffing levels, workload, organization of working hospital restructuring issues (Sovie and Jawad, 2001; Sochalski, 2004).
- **health care providers’ characteristics** such as caring and/or respecting behaviours, friendliness, responding timelinessy to patients’ requests, providing adequate explanations, clinical competence and nurses’ morale (Jacelon, et al., 2004; Geanellos, 2005; Yang and Huang, 2005).
- **patients’ sociodemographic characteristics** such as age, gender, ethnicity, education and income (Green and Davies, 2005). Research also suggests that gender seems to play a key role in patient satisfaction with hospitalization care and that women tend to be less satisfied. Therefore, it is suggested that there should always be a gender-sensitive approach in any effort to measure patient satisfaction to avoid the situation of unheeded women and maltreated men (Woods and Heidari, 2003; Foss and Hofoss, 2004).

Even more broadly, patient satisfaction has been associated with life satisfaction/general health and has been explored through various questionnaires such as MHIQ (The McMaster Health Index Questionnaire), LSIA (Life Satisfaction Index A & B), QWBS (The Quality of Well Being Scale), the Perceived Health scale, or even more specifically with tools targeting nursing care (Laschinger et al., 2005, Facouri and Lyon, 2005). Once the data is acquired, the next problem arises when an attempt is made to rank satisfaction on a scale. However, patient satisfaction should not be used as a sole indicator for the quality of care and vice versa, as research findings from Finland and USA suggest that satisfied patients also more readily express reasons for dissatisfaction (Kuuppelomaki et al., 2004; Jennings et al., 2005).

A better understanding of quality of life calls for more intense theoretical and methodological work rather than an increase in the amount of social and environmental statistics. Here, as elsewhere, data without ideas are sterile if not misleading. His statement holds true to this day. Many contemporary researchers include, in their patient satisfaction indicators, questions about patient perception of the ward, its equipment, sanitary conditions, meals, activities and care (Chang et al., 2006).

The use of surveys in patient satisfaction measurements is advocated, providing that appropriate and specific questions are asked. Yet, it has been argued that patient satisfaction questionnaires do not access an independent phenomenon but actively construe it, as respondents are forced to express themselves in alien terms. Thus, often due to rigid formats, questionnaires may be very misleading, e.g. focusing attention on aspects the researcher thinks are important, and overlooking issues crucial to the patient and therefore limiting the responses. Answers are only as good as the questions you ask; sound questionnaire design is imperative (Burgio et al., 2006).

**Measuring satisfaction**

As yet, there is no “golden standard” for measuring patient satisfaction. The techniques employed range from indirect measures focusing on beliefs, attitudes and expectations to direct satisfaction/dissatisfaction rating
on various scales and mixed satisfaction/dissatisfaction measures.

There is a danger however, of relying too heavily on standard instruments of "satisfaction" when assessing the quality of care that people receive. Research has indicated that reported levels of satisfaction with health care are almost always misleadingly high for people who are often reluctant to appear critical of hospital services (Scotti, 2005). These services may be seen to be supplied by "dedicated" professionals, underpaid health care staff or professionals who 'deserve every penny they get'.

Generally speaking there is also a fear that any criticism might be seen as a direct complaint. Thus, when interpreting high mean scores of patient satisfaction levels, which are measured by means of scales of highly structured questionnaires, one should keep in mind the tendency of most people to be biased toward the "very satisfied" end of the scale. This bias is primarily associated with people's hesitancy to give negative or socially unacceptable answers. Therefore, a mean satisfaction score of 6 on a 7 point Likert scale (where 1 = extremely dissatisfied and 7 = extremely satisfied) may not necessarily imply that the majority of patients are satisfied with various aspects of their hospital stay.

A health care situation comprises of several aspects and attributes. Thus, if patient satisfaction studies are to be more useful they need to produce global and overall measures of satisfaction as well as specific information on characteristic components of the service. Finally, it should be stressed that research which is properly designed to assess patient satisfaction should not only aim to provide feedback to the health care system but it should also attempt to make the patient see that the questions are asked by a caring health care professional who is wishing to improve present and future services and to satisfy clients.

Any attempt to measure satisfaction should take into account patients' autonomy and dignity, as these are paramount elements of a persons' identity. McCormack (2001) recorded 14 case studies and used conversation analysis and thematic analysis. His research challenges the definition of autonomy proposing an alternative view of autonomy based on interconnectedness and the nurse-patient relationship. In this way, the patient is empowered through negotiation with the nurse, so they manage his condition jointly as equal partners.

Patient satisfaction and quality of care
Taking account of the views of the consumer has permeated all public services and other organisations which have a consumer-provider interface. In this context, the white paper "Working for Patients", introduced the notion of delivering care in a way which aims to meet the expressed wishes of patients' and also has put emphasis on measuring patient satisfaction with health care. Many authors suggested that this white paper also enabled the consumer's voice to be heard through the reorganisation of the Community Health Councils (Lothian and Philp, 2001).

Despite a well established interest in the quality of care that patients receive, it is worth while looking at issues such as who is being evaluated and by whom? The largest volume of nursing quality assurance studies, between 1992-2002, focused on the nursing care of the hospitalised young adult. The more recent speciality of gerontological nursing has shamefully received less quality assurance research attention compared to other specialities. "Consumerism" may not extend to all constituencies of the health service, but may be concentrated in the acute sector, leaving the more vulnerable and less articulate groups with little or no representation (Clausen et al., 2006).

Even within the hospital sector, there seems to be a certain very complex age-productivity bias which is a reflection of current social values; the bulk of research tends to concentrate on the "productive" adult, or "the productive to be" child, leaving little room for the "unproductive" elderly's needs to be addressed. In the case of the young adult or child success of treatment can be measured in the reduced length of hospital stay or the speed at which they return to work or school. For the retired elderly though these parameters are not applicable and finding tools to indicate recovery in a turbulent financial environment can be difficult (Tokunaga and Imanaka, 2002).

There is much debate around the issue of trying to meet patients' needs. When the meaning of "health" among consumers was compared with the one given by nursing models, findings suggested that the consumer may view health in broader terms than clinical measurements. It should also be noted that occasionally, auditing tools used, tend to reflect the 'standards' set by the author rather than those of the user. Finally, questions are often raised with regard to the usefulness of data in patient satisfaction and quality assurance, where it focuses on aspects of institutionalised life (Williams et al., 2005).

Mary Courtney et al (2000), have conducted an extensive literature review of acute care nurses towards older patients, examining issues such as attitudes of nurses in long-term and acute care settings. Other issues also discussed include, knowledge about aging and ageism as a social stereotype. They state that "Nurses with positive attitudes towards older people hold many negative stereotypical ageist attitudes about older people. These negative attitudes might have a significant effect on the quality of care the older patients receives."

Patient satisfaction and costs
British hospitals, from the 1960s onwards, found themselves injected with a new 'managerialism' based on the industrial model of scientific management. It was initially proposed that hospitals would increase their efficiency (quality of care) if based on the economy of scale of large units. Thus the goal for every successful manager is to minimise the costs whilst maintaining quality. Free competition may reduce quality for the
sake of an immediate competitive advantage. On the other hand, lowered standards may also be seen as an inevitable by-product of inflationary pressures of rising material and labour costs.

Since hospitals are becoming industrial-like organisations, should managerial, industrial and financial issues be addressed in conjunction with the quality of care (the product?) which patients (the customers?) receive (buy?). As far as consumer expectation is concerned, these issues can be associated with consumer satisfaction or dissatisfaction such as complaints about the service which can also be translated in financial terms. An unhappy customer is not going to be a customer any more and, as a rule-of-thumb, one complaint can cancel a hundred compliments. Therefore, it can be argued that a major underlying reason for evaluating quality of care is to determine cost effective procedures or even profitability.

With regards to rapidly rising costs, health workers including nurses should investigate why their services have become so over utilised that the balance between supply and demand has grown out of hand, especially in countries with a well developed system of social services. However, it should be noted that modern medicine and its technical applications are the products of industrialized civilisation and that most nurses dislike analogies made between industry and our profession. We dislike the concept of being industrial workers in a health care factory. Nevertheless, links between patient satisfaction and the nursing service seem to be quite strong as evidence suggests that the patients’ opinion of nursing probably reflects on their hospital experience as a whole (Chao and Roth, 2005).

Political Issues
The UK’s Patients’ Charter introduced in 1991 (but abolished in 2000 and replaced by the 10 year NHS plan) categorically put emphasis on the NHS patient as a client, because “after all... they can not take their custom elsewhere if they are dissatisfied” (The patient’s charter, 2001).

Furthermore, the recent NHS reforms have introduced a purchaser/provider split between health authorities and units. Health authorities are now expected to identify the health needs of their resident population and purchase health services from units accordingly. In addition, the competition of the internal market is theoretically expected to ensure and increase the quality of care that patients receive and consequently the resulting satisfaction with the service as well. In practice, this concept can be examined with quantitative, qualitative or even mixed indicators, such as ensuring that legislative and statutory requirements which reflect upon standards of care are being met; waiting times are reduced, infection/pressure sore rates and complaints through patient satisfaction surveys are kept to a minimum. The consequences of these new arrangements on services for the elderly have yet to be determined. Are we ensuring that the elderly will get a high standard of care or perhaps are we imposing our own views on them? It should also be pointed out that the auditing tools that were used tend to reflect the “standards” set by the author rather than those of the user.

Over too often, the typical trap which is easy to fall into is this stereotypical saying: “I know what is best for you”. Although phrases like this may seem appropriate to the nurses who are trying to be friendly with their elder clients, they can be part of a stereotype communication which does not promote nurse-elder interaction on an equal and mutually respectful basis (Gardner et al., 2001). Nevertheless, one should always keep in mind that it is the elderly patients who are actually experiencing the care, not us. Once again it is easy enough to measure the quality of care provided and consequently patients’ satisfaction by monitoring self-imposed standards by our criteria but to what degree have we actually met the needs of the consumer of the service?

Variations in who is interviewed in research investigation, the timing of the interview, the type of questionnaire used and how satisfaction is rated, have a major influence on the results and make comparisons extremely difficult. It has also been argued that that the future of aging persons in an aging society will depend upon our attitudes and behaviours. Fortunately, our perception of the elderly is not static. In some sections of society it should, undergo re-evaluation from the retired ‘inactive’ grandparent to the more active and participative role of most elderly people. In terms of elderly patients, they should not just "be seen" but more importantly "heard" (Geest et al., 2005).

Hearing and genuinely accepting the views of seniors could also help us provide a service “free of bad surprises” (Sofaer et al., 2005). That is, a service catering for the needs of the elderly and their ideas about health care. After all, consumers may view health in broader terms than clinical measurements. Therefore, nurses must consider each consumer’s health views and goals and assist them toward attainment of these goals (Sixma et al., 2000).

Ageing and its Social Dimensions
Ambivalent attitudes towards ageing have been an issue for millennia. Plato’s affinity towards the elderly is in contrast with many ancient Greeks who held the view that: “ageing does not come alone; it brings disaster with it” (Anonymous). This pessimistic view can still be found today, where physical and psychological changes that are due to the normal process of ageing, are regarded as "negative" or "disastrous" changes.

Many people are tremendously influenced by the visual effect of changes in physical appearance. Such changes include wrinkling of the skin, altered facial architecture and stooped body posture, together with sensational changes like diminished vision, hearing and taste, slower psychomotor performance, altered sleep patterns and mild memory loss. These changes can influence our perception of elderly people and may result in a tendency to consider them “just depressed” without seriously tackling the underlying pathological causes.
Yet many of these changes are not necessarily just age-related. It is well known that misinterpretations, misperceptions and nihilism against the elderly have resulted in a well-established age-bias in some segments of western societies. Various studies suggest that even society's so-called health experts, GPs, are not always able to interpret the biological ageing process compared to genuinely pathological declining health and energy (Knaefelc et al., 2003).

Although bias itself is not a new and striking concept, there is something particularly interesting about the age-bias. Unlike the sex-bias or the ethnic minority biases, the age-bias is not legitimized. On the contrary it has gradually and implicitly reached a state in many sections of society where it is accepted and justified silently. People may recognise and accept the fact that there is a certain age-bias but due to some social "conspiracy" against the elderly they seem to be reluctant to take action against this bias. There are various cultural and political issues involved. What is needed is more resource allocation and encouragement of more positive attitudes towards elderly people in general, even a greater exposure of children to the elderly in schools.

Hospitalization is connected with cultural issues and the elderly. When exploring patient satisfaction, aspects of care related to respect, disrespect, assumptions and beliefs about ageing should be expected to emerge as well. Services should cater to needs rather than age segregation per se (Gonzalez et al., 2005).

Hospitalization of the elderly
In England during the last century, the number of people over 65 years of age increased 4-fold and those over 85 years old 7-fold. This age group was hospitalized more than any other age group. In terms of polypharmacy there is a significant increase due to hospitalization. Research also suggests that there is a risk of decisional uncertainty about treatment, concerning elderly patients on acute medical wards. Perhaps the most hazardous effect of hospitalization on the elderly is a functional decline including a negative emotional response which is associated with a risk of additional psychological stress (Hill and Doddato, 2002).

Consequently, there are a significant number of patients who refuse hospitalization. This decision may be due to factors such as fear or other causes which need to be addressed. Thus, it can be stated that, due to hospitalization and to our beliefs and general attitudes with regard to ageing, elderly patients often feel additional pressure within the hospital environment (Griffin, 2004). Subsequently, we must recognize when attempting to assess patient satisfaction that it is important to seek patients' views, taking into account their personal circumstances. This way, we hope to avoid protective responses especially from elderly patients who may be reticent about expressing dissatisfaction.

It is important to recognize that developing patient satisfaction tools is a limiting task due to a lack of a "gold standard" against which results can be compared. However, this important health care related issue nevertheless needs to be examined and addressed for nurses and allied personnel to enhance their everyday delivery of care. After all, key elements like satisfaction and contentment are deeply built within our day to day interaction with clients. Unfortunately rigorous research in this vital field is almost impossible due to methodological difficulties of defining satisfaction itself.

Older patients' satisfaction
Human satisfaction is a complex concept which is related to a number of factors including past experiences, life style, future expectations and the values both of the individual and society (Aragon, 2003). Patient satisfaction can be summarized as the patients' views of their care and it is most widely used unspecific measure of outcome. It has also been suggested that patient satisfaction is one form of outcome that can be used to measure the quality of services provided (Jacelon et al., 2004).

Elder patients' satisfaction is of great significance and needs to be explored further because despite the fact that elderly people are the main consumers of health and social services, many nurses working in elderly care have been slow to grasp its implications for practice. There are three practical reasons why patient satisfaction should be repeatedly assessed: firstly, it is an outcome of care; secondly it is a contributor to this outcome; and thirdly it is the patients' judgement of the quality of care. These issues are of crucial importance to nurses; many studies have shown that satisfaction with the nursing service was found to be the only variable directly related to overall satisfaction with hospital stay. This places patient satisfaction outcomes squarely on the shoulders of nursing staff. Recently, Castledine (2005) writes of a continuous need for better communication with older people. This alone in turn, should lead to improved patient satisfaction.

Courtney et al. (2000) state that attitudes towards older patients significantly influence nursing practice. Nurses who placed a high degree of importance on talking to patients held more positive attitudes than those who placed a high degree of importance on general nursing care (bathing, toileting). It is yet to be ascertained whether techniques which help us as nurses to converse with patients will also enhance us with even more positive attitudes towards the elder recipients of our care.

Unfortunately, it is often assumed that all nurses automatically know how to initiate a conversation effortlessly, showing genuine interest in an elderly patient. However, in practise, we need assistance to improve our interpersonal 'people's skills' crucial to use with elderly patients, especially those who put on a brave face masking, fears, loneliness or anxiety.

French (2003) in her excellent review of methodological considerations in hospital patient opinion surveys, attempts to answer the specific questions of when, where and how it is most productive to ask hospital patients for their opinions. She states "There are no clear-cut answers to the questions of when, where
and how to best obtain patients’ opinions”. Research carried out as close to the relevant events as possible with multiple sessions with patients covering the course of their hospital stay, seems most illuminating.

Great importance is attached to the actual wording of questions which need to be tested to see if the individual questions fail to elicit the patients’ opinion or indeed misrepresent them. Bridging the gap between research principles and day to day nursing practice, such observations place nurses at an exceptional advantage for they are readily available to lend an ear to patients’ core needs.

Summary and Implications for Practice
Research within this discussion paper has shown that identifying patients’ needs, especially those of the elderly, is best sought as close to a health threatening event as possible. What is needed at present are not more surveys on satisfaction but research on brief key questions that we as nurses, could negotiate with patients eliciting truthful, constructive insight into their nursing needs.

Satisfaction measurements are not routinely used in many E.U. countries or health care environments especially where nursing staff are seriously short-staffed. There is obviously a need to kick-start our reflective practice even for those nurses handicapped with low staffing levels or shortness of time. The following three simple questions, already incorporated into the routine of many experienced nurses, could serve as a reasonable start to initiate a greater effort on quality service and patient satisfaction in almost any circumstances. The first question is patient orientated, the second and third nurse and service orientated respectively. The simple questions suggested below can be asked informally as part of a purposeful nursing dialogue. Dignity is an issue here: all three must be addressed with politeness and genuine concern, respecting the name by which the patient wishes to be addressed. The purpose of the questions is to provide a setting for patient/nurse negotiations where patients’ needs are explored.

- How do you feel today and how is that different to yesterday? (patient-orientated question).
- What have you liked most about our nursing? (nurse-orientated question).
- How do you think we could make our services even better? (service-orientated question).

These open-ended questions ‘overpowered’ with simplicity are reaching out questions which are carefully addressed in non-threatening, everyday language. The answers can be both rewarding and revealing. Furthermore, they can be asked while conducting simple tasks such as rearranging the patient’s position in bed. Having asked the questions it is, of course, imperative to respond accordingly, taking short or long term appropriate action. The ultimate achievement is a truly cost effective, continuing needs assessment. Finally, it goes without saying that the core of our nursing care is to put patients/clients at their ease in all aspects, physical, emotional, therapeutic and spiritual in order to enhance the healing state. These key questions, which have arisen from nursing experience and from the extensive reading of the references in this discussion paper, provide every nurse with a ‘handy’ tool for assessing and day to day striving toward patient satisfaction.

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