

Comparative Assessment of Patient Satisfaction with Nursing Care and its Determinants in Public and Private Hospitals

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Abstract

Background: Patient satisfaction reflects how well nursing care meets patients' needs and expectations, given nurses' central role in inpatient care delivery. Public and private hospitals differ structurally, and while private hospitals sometimes show higher satisfaction, evidence suggests care delivery matters more than ownership itself.

Objective: To compare nursing-care satisfaction in public and private hospitals and identify factors independently associated with high satisfaction.

Methods: The study used analytical cross-sectional study design with a sample size of 360 adult inpatients, equally divided between public and private hospitals. Newcastle Satisfaction with Nursing Scales scores were transformed to 0–100. Reliability analysis, descriptive statistics, Independent-samples t test, chi-square analysis, and binary logistic regression were performed.

Results: Mean satisfaction was higher in the private hospital (M = 72.32, SD = 11.35) than in the public hospital (M = 64.12, SD = 11.07), Welch's $t(357.77) = -6.94$, $p < .001$, mean difference = 8.19, 95% CI [5.87, 10.52], Hedges' $g = 0.73$. High satisfaction occurred in

44.4% of private-hospital patients and 18.3% of public-hospital patients, $\chi^2(1) = 27.29$, $p < .001$. Cronbach's alpha was 0.892 for satisfaction and 0.913 for experience. After adjustment, private ownership was not significant (aOR = 1.25, 95% CI [0.64, 2.41], $p = .515$). Higher cleanliness, privacy, and communication ratings increased the odds of high satisfaction, whereas longer waiting time, female gender, and surgical-ward admission reduced the odds.

Author Details

Keywords: Patient Satisfaction; Nursing Care; Newcastle Satisfaction With Nursing Scales; Public Hospital; Private Hospital; Communication; Waiting Time.

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Conclusion: The unadjusted public–private difference was substantial, but modifiable care-process factors were more informative than ownership after adjustment. Nursing quality improvement should prioritize communication, privacy, cleanliness, and timely responsiveness.

Introduction

Background

Patient satisfaction is a patient-reported outcome reflecting the extent to which health care meets patients' expectations, needs, and values. Within inpatient services, nursing care is central because nurses provide continuous assessment, medication administration, emotional support, education, hygiene care, surveillance, discharge preparation, and coordination. Patient feedback therefore provides clinically meaningful information about both interpersonal care and the reliability of hospital processes (Akin, 2007; Al-Balushi, 2014).

The Newcastle Satisfaction With Nursing Scales (NSNS) were developed specifically to measure patients' experiences of nursing care and their satisfaction with that care. The instrument separates experience from satisfaction and converts each scale to a 0–100 score, with higher values representing more favorable evaluations. The original evaluation demonstrated good internal consistency, construct validity, and sensitivity to variation between wards and hospitals (Thomas et al., 1995, 1996, 1996). Subsequent validation studies have supported its use in diverse clinical and cultural contexts (Akin, 2007; Peterson et al., 2005).

Public and private hospitals may differ in patient volume, staffing, amenities, direct payment, waiting time, privacy, and organizational responsiveness. These structural differences can influence processes of nursing care, but ownership itself may be less important than the way care is delivered. Comparative evidence indicates that private hospitals sometimes achieve higher satisfaction, although the size and significance of the difference vary across settings (Dinsa et al., 2022).

Problem Statement

Local comparative evidence focused specifically on nursing care in public and private hospitals remains limited. Without analysis that separates hospital ownership from modifiable processes such as communication, privacy, cleanliness, and waiting time, nursing leaders may incorrectly attribute dissatisfaction to ownership alone. A nursing-specific assessment is needed to identify where improvement efforts should be directed.

Significance of the Study

This study is significant for nursing practice, management, and quality improvement. It provides a patient-centered assessment of nursing care, compares public and private settings, and identifies modifiable factors that can be addressed through staff development, ward management, and service redesign. Use of a validated nursing-specific instrument also improves comparability with international evidence.

Research Objectives

Primary objective: To determine the level of patient satisfaction with nursing care among adult inpatients in public and private hospitals using the NSNS.

Secondary objectives:

To compare NSNS satisfaction scores between public and private hospitals.

To describe overall experience, satisfaction, and combined NSNS scores.

To determine associations between high satisfaction and selected patient and hospital factors.

To identify independent predictors of high satisfaction after adjustment for covariates.

Research Questions

What is the level of patient satisfaction with nursing care among adult inpatients?

Does mean NSNS satisfaction differ between public and private hospitals?

Which patient-related and hospital-related factors are associated with high satisfaction?

Which factors independently predict high satisfaction?

Hypotheses

H₀: There is no significant difference between public and private hospital inpatients mean NSNS satisfaction scores.

H_A: There is significant difference between public and private hospital inpatients mean NSNS satisfaction scores.

Literature Review

Conceptualizing Patient Satisfaction with Nursing Care

Patient satisfaction is multidimensional and reflects the comparison between expectations and perceived care. It incorporates interpersonal respect, information, empathy, responsiveness, technical confidence, privacy, comfort, and environmental conditions. Satisfaction is not identical to objective quality, but it is an important patient-reported outcome because it captures dimensions of care that may be invisible in routine clinical indicators (Wagner & Bear, 2008).

Donabedian's structure–process–outcome framework is useful for organizing these determinants. Structure includes hospital ownership, staffing, supplies, and ward environment. Process includes nurse–patient communication, responsiveness, privacy practices, education, and waiting time. Outcomes include satisfaction, confidence, adherence, and willingness to recommend the institution (Donabedian, 2015). In this study, ownership and ward type are structural variables, communication and waiting time are process variables, and NSNS satisfaction is the principal outcome.

Newcastle Satisfaction With Nursing Scales

The NSNS arose from qualitative work on patients' views of nursing care and was subsequently tested across multiple wards and hospitals. It contains a 26-item experience scale and a 19-item satisfaction scale. Scores are transformed to a 0–100 metric; higher experience scores represent more positive nursing experiences, and higher satisfaction scores represent greater satisfaction (Thomas et al., 1995, 1996).

Evidence from postpartum, medical–surgical, Turkish, and Italian samples supports the instrument's reliability and validity (Akin, 2007; Alotaibi, 2024; Peterson et al., 2005). Nevertheless, translation, item order, response anchors, and reverse-scoring keys must be checked against the authorized version used in each study. Differences in instruments and thresholds also mean that prevalence estimates of “satisfaction” should not be compared without considering scoring methods.

International Evidence and Public–Private Differences

International studies show substantial variation in nursing satisfaction. (Dinsa et al., 2022), using the Newcastle scale in Ethiopian public and private hospitals, reported modestly higher satisfaction in the private hospital but no statistically significant ownership difference. Factors included cleanliness, length of stay, admission history, ward space, and perceived nursing capacity. More recent Ethiopian evidence has also shown that satisfaction varies by ward and patient characteristics (Alotaibi, 2024; Zahid & Aniba, Ali Saman, Atiq Zumirah, Zunaira, 2024).

A systematic review of Asian studies identified physical environment, service quality, waiting time, communication, accessibility, affordability, provider behavior, and patient characteristics as recurring determinants (Afridi et al., 2024). This supports a model in which hospital ownership may influence satisfaction indirectly through resources and care processes rather than acting as an independent causal factor.

Recent NSNS-based evidence from Saudi Arabia reported generally high nursing satisfaction but continued variability across demographic and care characteristics (Alotaibi, 2024). These international differences likely reflect health-system organization, patient expectations, ward mix, measurement choices, and cultural norms, emphasizing the need for context-specific interpretation.

Communication, Responsiveness, and Nursing Presence

Communication is among the most consistent predictors of nursing satisfaction. Patients evaluate whether nurses listen, explain procedures, answer questions, provide reassurance, and use respectful language. (Lotfi et al., 2019) demonstrated a close relationship between nurse–patient communication and satisfaction, while (Akin, 2007) linked poorer patient evaluations to missed nursing care and reduced confidence in nurses and physicians. Regular nursing presence and timely responses can therefore improve both perceived safety and trust.

Privacy, Cleanliness, and Waiting Time

Privacy protects dignity during examinations, personal care, medication administration, and communication. Cleanliness contributes to perceptions of safety, competence, and organizational control. Waiting time signals responsiveness and influences whether patients believe their needs are being prioritized. The Asian systematic review by (Afridi et al., 2024) and the public–private comparison by (Dinsa et al., 2022) both identify environmental quality and service responsiveness as important. These factors are directly relevant to the present model.

Patient and Ward Characteristics

Associations between satisfaction and age, gender, education, admission history, and ward type are inconsistent. (Al-Balushi, 2014) found that male gender and lower education were associated with satisfaction in one Ethiopian setting, whereas a Karachi study found no gender association. Ward findings also differ: clinical dependency, pain, anxiety, expectations, and nurse workload may vary between medical, surgical, obstetric, and orthopedic services. Such inconsistency indicates that demographic effects should be interpreted cautiously and not treated as universal (Kasa, 2019).

Evidence from Pakistan

Pakistani evidence generally shows moderate-to-high satisfaction but identifies important gaps in information, communication, workload, and the service environment. (Afridi et al., 2024) reported high overall satisfaction in a Karachi public tertiary hospital, with communication receiving particularly favorable ratings. In contrast, (Zahid et al., 2024) reported moderate satisfaction and identified information provision as the lowest-rated area. (WHO, n.d.) found mostly moderate or high satisfaction but no gender association in a small Karachi sample. These differences reinforce the need for standardized nursing-specific measurement and adequately powered comparative studies.

Methodology

Study Design

An analytical cross-sectional design was used. The design estimates satisfaction and evaluates associations at one point in time.

Study Setting and Population

The target population is adult inpatients in medical, surgical, gynecology/obstetrics, and orthopedic wards.

Eligibility Criteria

Table 1

Eligibility Criteria

Inclusion criteria	Exclusion criteria
Age 18 years or older	Critically ill or unable to respond
Admitted for at least 48 hours	Altered consciousness or severe cognitive impairment
Admitted in a selected inpatient ward	Discharged before consent/data collection
Able and willing to provide informed consent	Refusal or unresolved language barrier

Sample Size and Sampling

The study contains 360 participants, including 180 public-hospital and 180 private-hospital patients. A stratified sampling was used by hospital and ward, followed by proportional systematic or consecutive recruitment according to admission flow. The equal allocation supports stable public–private comparison but should not be mistaken for a prevalence-weighted hospital population.

Data Collection Instrument and Scoring

The data form contains demographic characteristics, hospital-related factors, 26 NSNS experience items, and 19 NSNS satisfaction items. Experience items were scored using the direct/reverse key embedded in the dataset, and satisfaction items were scored in the positive direction. Both scales were transformed to 0–100. The combined overall score was the arithmetic mean of the experience and satisfaction scores. High satisfaction was defined as a satisfaction score of 75 or higher.

Validity and Reliability

Internal consistency was evaluated with Cronbach's alpha. Values of .70 or higher were considered acceptable for group-level research.

Data Analysis

Data were analyzed using SPSS 26 version. Frequencies and percentages summarized categorical variables; means and standard deviations summarized continuous scores. Welch's independent-samples t test compared hospital satisfaction means and was reported with a 95% confidence interval and Hedges' g. A 2×2 chi-square test with continuity correction compared high satisfaction by hospital type; the uncorrected odds ratio and 95% confidence interval were also calculated.

Binary logistic regression modeled high satisfaction. Predictors were hospital type, age, gender, length of stay, waiting time, cleanliness, privacy, communication, and ward type. Public hospital, male gender, and medical ward were reference categories. Results are reported as adjusted odds ratios (aORs), 95% confidence intervals, and p values. Model fit was summarized using the likelihood-ratio chi-square, Nagelkerke R^2 , Hosmer–Lemeshow test, and classification accuracy. Statistical significance was set at $p < .05$.

Ethical Considerations

Ethical approval was obtained from the institutional ethical review board, of the hospitals, informed consent was taken from every participants, and confidentiality was safeguards.

Results

The study contained 360 participants, with 180 participants from each hospital type. No duplicate IDs or blank cells were detected.

Participant Characteristics

Table 2

Selected Participant Characteristics (N = 360)

Characteristic	Category	n (%)
Age group	18–30	97 (26.9)
	31–45	133 (36.9)
	46–60	100 (27.8)
	>60	30 (8.3)
Gender	Male	180 (50.0)
	Female	180 (50.0)
Residence	Urban	219 (60.8)
	Rural	141 (39.2)
Ward	Medical	120 (33.3)
	Surgical	118 (32.8)
	Orthopedics	49 (13.6)
	Gynecology/obstetrics	73 (20.3)
Previous admission	No	238 (66.1)
	Yes	122 (33.9)
Nurse identified	No	143 (39.7)
	Yes	217 (60.3)

Note. Percentages are based on the full sample. Mean age was 40.52 years (SD = 13.40).

NSNS Score Distribution and Reliability

Table 3

NSNS Descriptive Statistics and Internal Consistency

Scale	Items	M	SD	Minimum	Maximum	Cronbach's α
Experience	26	74.38	9.10	48.72	97.44	0.913
Satisfaction	19	68.22	11.92	34.21	93.42	0.892
Overall combined score	—	71.30	10.27	41.47	94.78	—

Note. All scores range from 0 to 100. Reliability was excellent for both NSNS component scales.

The experience and satisfaction scores were strongly correlated, $r = 0.91$, $p < .001$. Overall, 20 participants (5.6%) were classified as having low satisfaction, 227 (63.1%) as moderate, and 113 (31.4%) as high.

Comparison of Satisfaction by Hospital Type

Table 4

Mean NSNS Satisfaction Scores by Hospital Type

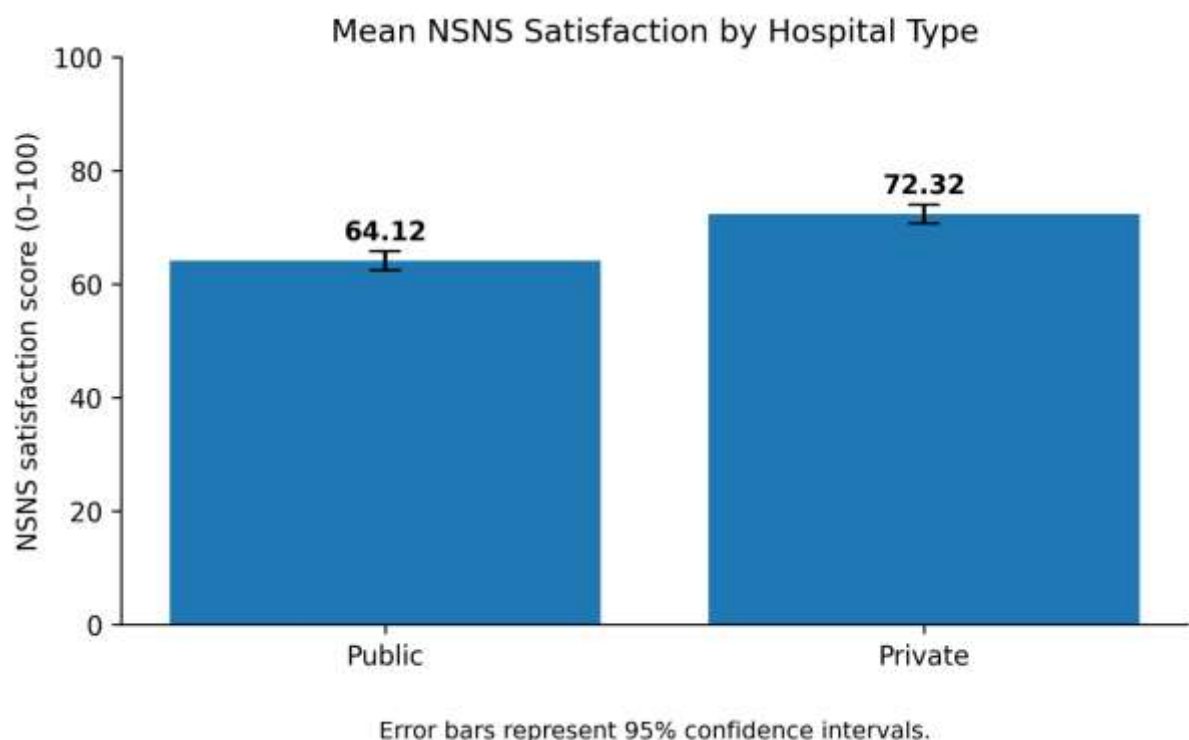
Hospital type	n	M	SD	95% CI for M
Public	180	64.12	11.07	[62.50, 65.75]
Private	180	72.32	11.35	[70.65, 73.99]

Note. Welch's $t(357.77) = -6.94$, $p < .001$; mean difference (private – public) = 8.19, 95% CI [5.87, 10.52]; Hedges' $g = 0.73$.

Private-hospital patients had substantially higher mean satisfaction than public-hospital patients. The standardized difference was medium-to-large.

Figure 1

Mean NSNS Satisfaction by Hospital Type



High Satisfaction by Hospital Type

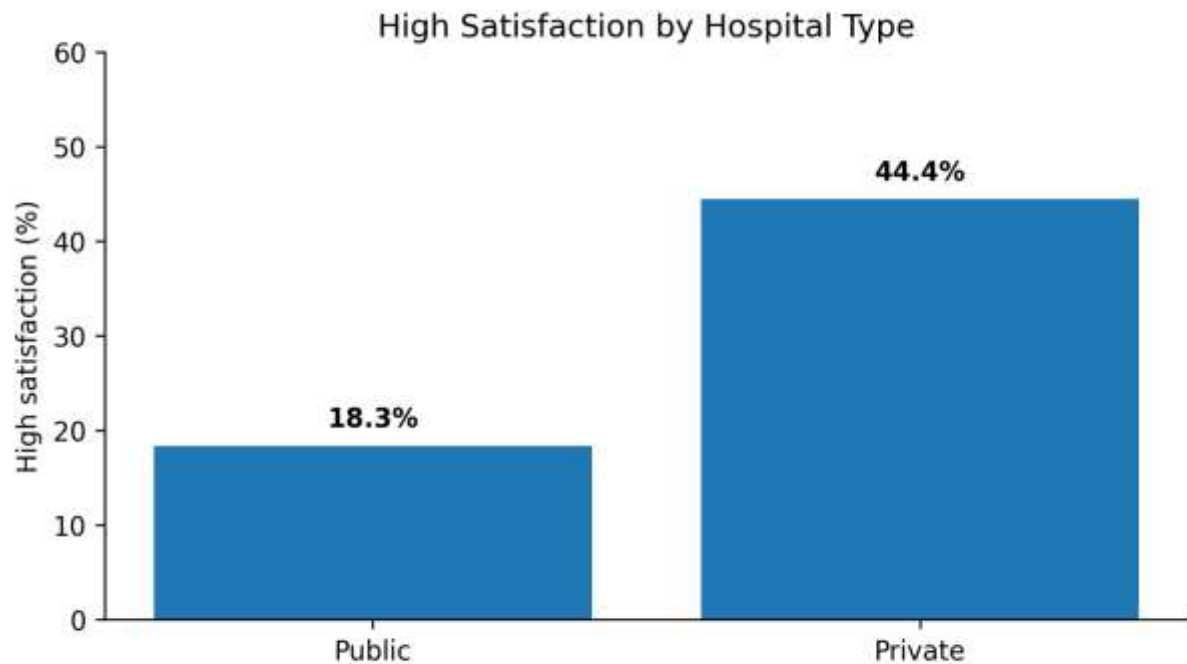
Table 5

High Satisfaction by Hospital Type

Hospital type	Low/moderate, n (%)	High, n (%)	Total
Public	147 (81.7)	33 (18.3)	180
Private	100 (55.6)	80 (44.4)	180

Note. High satisfaction was defined as an NSNS satisfaction score ≥ 75 . Continuity-corrected $\chi^2(1) = 27.29$, $p < .001$. The unadjusted odds ratio for private versus public hospitals was 3.56, 95% CI [2.21, 5.75]; $\phi = 0.28$.

The proportion with high satisfaction was 26.1 percentage points greater in the private hospital. Before adjustment, private-hospital patients had 3.56 times the odds of high satisfaction compared with public-hospital patients.

Figure 2*Percentage of Patients With High Satisfaction by Hospital Type*

High satisfaction was defined as an NSNS satisfaction score of 75 or above.

Bivariate Associations

High satisfaction was associated with hospital type, $\chi^2(1) = 27.29$, $p < .001$; age group, $\chi^2(3) = 7.88$, $p = .049$; gender, $\chi^2(1) = 4.18$, $p = .041$; and ward type, $\chi^2(3) = 15.89$, $p = .001$. Waiting time was negatively associated with high satisfaction (point-biserial $r = -.27$, $p < .001$), whereas cleanliness ($r = .19$, $p < .001$), privacy ($r = .20$, $p < .001$), and communication ($r = .21$, $p < .001$) were positively associated. Marital status, education, employment, residence, previous admission, nurse identification, age as a continuous variable, length of stay, and illness severity were not significant in these bivariate tests.

Independent Predictors of High Satisfaction

Table 6*Binary Logistic Regression Predicting High Satisfaction*

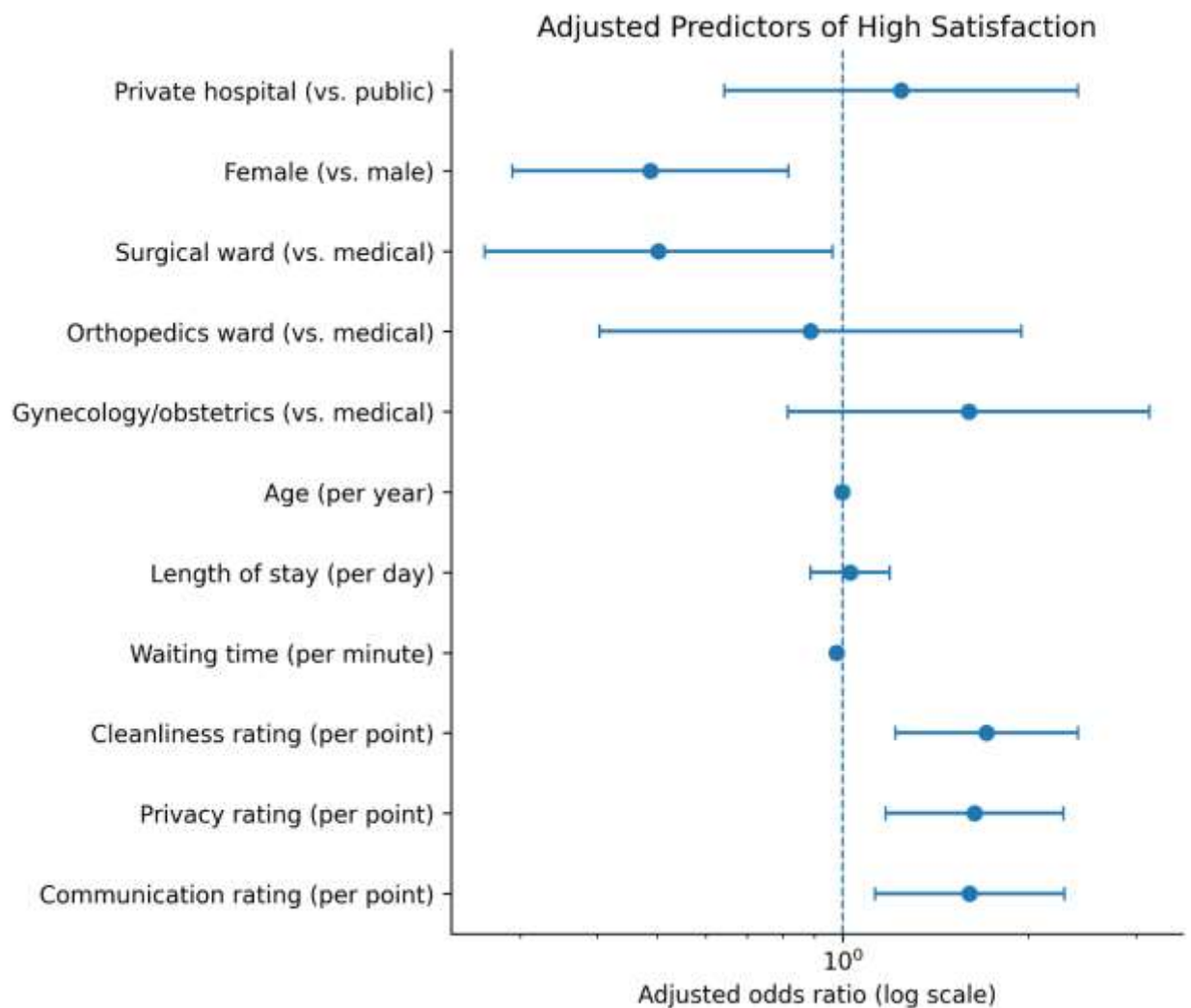
Predictor	B	SE	aOR	95% CI	p
Private hospital (vs. public)	0.219	0.337	1.25	[0.64, 2.41]	.515
Female (vs. male)	-0.719	0.263	0.49	[0.29, 0.82]	.006
Surgical ward (vs. medical)	-0.688	0.332	0.50	[0.26, 0.96]	.038
Orthopedics ward (vs. medical)	-0.119	0.403	0.89	[0.40, 1.95]	.767
Gynecology/obstetrics (vs. medical)	0.471	0.345	1.60	[0.81, 3.15]	.172
Age (per year)	-0.001	0.010	1.00	[0.98, 1.02]	.902
Length of stay (per day)	0.028	0.076	1.03	[0.89, 1.19]	.709
Waiting time (per minute)	-0.023	0.008	0.98	[0.96, 0.99]	.004
Cleanliness rating (per point)	0.538	0.174	1.71	[1.22, 2.41]	.002
Privacy rating (per point)	0.493	0.169	1.64	[1.17, 2.28]	.004

Predictor	B	SE	aOR	95% CI	p
Communication rating (per point)	0.475	0.180	1.61	[1.13, 2.29]	.008

Note. Outcome: high satisfaction (1 = NSNS satisfaction ≥ 75). Model likelihood-ratio $\chi^2(11) = 78.46$, $p < .001$; Nagelkerke $R^2 = 0.275$; Hosmer–Lemeshow $\chi^2(8) = 8.41$, $p = 0.394$; classification accuracy = 73.9%. Reference groups were public hospital, male gender, and medical ward.

After adjustment, hospital type was no longer statistically significant. Each one-point increase in cleanliness, privacy, and communication was associated with 71%, 64%, and 61% higher odds of high satisfaction, respectively. Each additional waiting minute reduced the odds by about 2%. Female patients had approximately 51% lower adjusted odds than male patients, and surgical-ward patients had approximately 50% lower odds than medical-ward patients. Age, length of stay, orthopedic ward, and gynecology/obstetrics ward were not significant.

Figure 3
Adjusted Odds Ratios for High Satisfaction



Discussion

The study analysis found that patients in the private hospital had higher unadjusted NSNS satisfaction than those in the public hospital. The mean difference of 8.19 points and Hedges' g of 0.73 indicate a meaningful standardized difference. High satisfaction was also more common in the private hospital. These findings are directionally consistent with Dinsa et al. (2022), although their public-private difference was smaller and not statistically significant, illustrating that ownership effects vary by setting.

The adjusted model provides the most important interpretation: hospital ownership was not independently significant after communication, privacy, cleanliness, waiting time, ward, and patient characteristics were included. This suggests that the observed public-private difference may operate through modifiable service processes. The finding is consistent with Donabedian's framework, in which structural conditions shape care processes, and processes then shape patient-reported outcomes (Donabedian, 1988).

Communication was an independent predictor of high satisfaction. This agrees with Lotfi et al. (2019) and the broader Asian review by (Afridi et al., 2024), which identify communication and provider behavior as recurring determinants. Communication may influence satisfaction by improving understanding, reassurance, participation, and trust. It is also a practical target for nursing education because respectful explanations, active listening, and timely updates can be strengthened without major infrastructure expenditure.

Privacy and cleanliness independently increased the odds of high satisfaction. These factors communicate dignity, safety, and organizational reliability. Dinsa et al. (2022) similarly identified cleanliness as important in public-hospital satisfaction. In Pakistan, studies have also highlighted communication, information, and the care environment as areas that shape satisfaction, although reported levels vary considerably (Afridi et al., 2024; Zahid et al., 2024).

Longer waiting time reduced the odds of high satisfaction. Waiting can be experienced as neglect, uncertainty, or lack of responsiveness, especially when patients are in pain or dependent on nursing assistance. The effect was modest per minute but can become meaningful across longer delays. Routine measurement of response time and visible communication during unavoidable delays may improve patient experience.

Female gender was associated with lower adjusted odds of high satisfaction, but the literature is inconsistent. Bogale et al. (2023) found higher satisfaction among men, while Rashad et al. (2023) found no gender association. Gender effects may reflect ward distribution, expectations, privacy concerns, communication patterns, or unmeasured social factors.

Surgical-ward patients had lower adjusted odds of high satisfaction than medical-ward patients. Surgical patients may have greater pain, anxiety, dependency, and expectations for rapid response. However, Abebe et al. (2024) reported higher satisfaction in surgical wards in a different context. The contrast supports the view that ward effects depend on workload, staffing, patient acuity, and local care organization.

Implications for Nursing Practice and Management

Implement structured communication training emphasizing explanation, active listening, empathy, and respectful language.

Strengthen bedside nurse introduction, patient orientation, and purposeful rounding.

Protect privacy during procedures, personal care, medication administration, and education.

Use ward-level cleanliness checklists with visible accountability and rapid escalation.

Track call-bell and request-response times and communicate openly when delays are unavoidable.

Review surgical-ward workload, pain management, discharge education, and staffing processes.

Disaggregate satisfaction reports by gender and ward to identify specific inequities or service gaps.

Limitations

The cross-sectional design cannot establish causality. One public and one private setting would limit generalizability in a real study. Satisfaction thresholds were dataset-defined, and patient expectations, staffing, nurse workload, pain, clinical outcomes, socioeconomic status, and payment method were not fully modeled.

Conclusion

The findings show higher unadjusted satisfaction in the private hospital, but hospital ownership was not independently significant after adjustment. Communication, privacy, cleanliness, and waiting time were the clearest modifiable predictors. Female patients and surgical-ward patients had lower adjusted odds of high satisfaction and warrant focused exploration. The central nursing-management implication is that patient satisfaction can be improved through better interpersonal communication, protection of dignity, environmental reliability, and timely responsiveness.

Recommendations

Use probability-based stratified sampling across multiple public and private hospitals. Include staffing, nurse workload, payment method, pain, expectations, and clinical acuity in future models.

Report both continuous NSNS scores and clearly justified categorical thresholds.

Use pre–post quality-improvement cycles to test communication, privacy, cleanliness, and response-time interventions.

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