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Patient satisfaction in relation to nursing care at home

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Abstract

With regards to home care, primary care nurses should carry out their activities and performance with an emphasis on health education. Considering patient satisfaction in the relationship aspect of helping and communication can contribute to improving nursing care. This cross-sectional, descriptive and analytical study, whose aim is to assess the degree of patient satisfaction in relation to nursing care provided at home, particularly in the dimensions of relationships, communication and health education. To conduct this research an intentional non-probabilistic sample, consisting of 44 dependent patients, belonging to the area of a health centre in the central region of Portugal, who receive nursing care at home was selected. The data collection instrument used was a form, consisting of two parts: the first part to characterise the sample with 10 questions, one of which is subdivided and the second part consisting of 16 Likert type scale questions to obtain the patients' opinions. From our results we stress that our sample had a very aged population, mostly residing in urban areas. Satisfaction was evaluated in three dimensions: relationships, communication and health education. With regard to relationships, older males (age range 88-98 years), who are more highly dependent, married, uneducated and living in rural districts are more satisfied. Regarding communication, older males (88-98 years), with a greater degree of dependency, bachelors, educated and living in urban parishes are most satisfied. As for the health education dimension, younger men (68-78 years), who are less dependent, married, educated and living in urban environments are more satisfied. The main conclusions inferred are that, in the overall assessment of all of the dimensions, the classification is very good, and it is suggested that organizational investments are made and to equip health centres with human and material resources.

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Keywords: Patient satisfaction; Nursing home care; Primary care nursing

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1. Introduction

As a result of the diagnosis and current therapeutic progress, the number of patients with chronic diseases has increased in recent decades. Progressive demands in terms of quality of life have led to new requirements in support of these patients and their families, not only in strictly medical aspects but involving other areas such as education, social security and employment (CNA, 2013).

The monitoring of these situations is critical and requires coordination by technicians with special skills as many health problems can be solved at home, thereby avoiding emergency visits and repeated hospital admissions, with the inevitable saturation of services. This presupposes the existence of organized health structures to enable continuity of care in the patient's home and a proper connection between this level of care and the hospital.

From the point of view of the benefits to chronically ill patients or to varying degrees of dependency on their families, continuity means that they will not be abandoned at any time during the course of the disease, as there will always be a familiar person to turn to in times crisis or decline, as well as to share in moments of triumph over adversity related to the disease (Small, & Small, 2011).

If the early diagnosis of chronic conditions and their complications is a current reality, enabling technicians and services to have a perspective of the population in need of care, continuous monitoring of treatment is no longer possible because existing health structures only allow periodic surveillance and control, according to the specific protocols of each pathology. Although they are flexible, the protocols do not seem to meet the needs experienced daily by patients and their families.

The continued provision of health care is one of the main objectives of the actions of professionals and primary health care, in which nurses should take on the role of catalyst for innovation and change and be responsible for helping patients and families suffering from a particular disease or dependence, within a given geographical area (Keleher, Parker, Abdulwadud & Francis, 2009).

Within the community nursing activities, home care is one of the basic strategies of intervention in the community. Thus, the house call is a set of health activities, both educational and as assistance in preventing disease and promoting health.

The house call is a nurse's activity with the support/assistance in terms of resolving patient/family problems. This support/assistance includes measures of education, interaction, guidance and autonomy. Thus, home care should seek to preserve what is most important in the profession, the helping relationship between nurse/person/family in need of health care (Ellenbecker et al., 2008).

The objectives of the house call are comprehensive, covering all stages of life of the individual in all three levels of prevention. As well as the nursing working method, they should: provide guidance and teach the family about existing methods and resources to protect and improve health and collaborate in solving their health problems; oversee compliance with prescriptions and vaccination schedules and other managed care by the family; collaborate on research and control of communicable diseases; provide nursing care at home, when it is convenient for the patient, family and the health care system, whether in economically, socially or psychologically; guide one or more family members to provide care at home; gather information on socio-economic conditions, the family's health, through interviews and observation (NACNEP, 2010; Mead, Andres, Regenstein, 2014).)

Assistance to the family through the house call has demonstrated its effectiveness in terms of a higher level of the population's health (CNA, 2013). So, the elderly continuing to live at home, report feeling better, even allowing some couples continue to live together, given that in certain circumstances, including being bedridden, could force prolonged hospitalization and creating a heavier financial burden for the community.

The house call is a felt need and experienced by large sectors of the community. It stands among the basic functions of the health team, priority health programs and social well-being. Its value in nursing necessarily involves from the outset, adequate planning based on a conceptual perspective. The cases, which may be included in a house call program, can be detected by various means. The request may come from the patient or family, when they do not have sufficient capacity or independence to resort to consultation and need home care on an ongoing basis. Ideally, the health team itself would detect these cases, either through nursing visits, or by reviewing the files, such as by age, sex, risk groups or case histories.

Another way is through community welfare organizations and hospitals, sometimes in order to continue care started in the latter.

House calls take place in a climate of mutual accountability of the individual, family and community with the health team professionals, always taking the person into account. Thus, this activity goes beyond the curative plan and allows instruction, guidance, promoting self-care, enhancing patient capabilities and their families to take on and tackle problems and to achieve the necessary coordination of all of the institutional human and material resources, (American Nurses Association, 2012).

The educational activity of the house call must focus on certain families or risk groups that are more vulnerable to health problems; however, we must highlight the progressive aging of the population, so many of the home-based care programs are directed especially to the elderly. Apart from this group of patients, we must also consider those with debilitating chronic disease, long-term pathologies, such as strokes, poly-trauma, terminally ill patients, who in most cases are of advanced age, also require control and periodic supervision by the team. For the patient staying with the family has many advantages, among which are the following: food will differ less than their usual diet, they will rest better at night, they do not depend on rigid timetables, they remain in a significant environment, it favours contact with family and friends.

Providing knowledge to individuals within their real context or environment, characterised by their dwelling, or the affective and social relations between the various family members, are some of the important factors to be identified to provide comprehensive health care. The patient remains integrated in their socio-familial and cultural surroundings.

Health care costs are lowered. Hospitalisation days are more expensive than house calls (relationship of hospitalisation day/house call). There are fewer hospital admissions because when patients are not accompanied at home and are released early, they easily require healthcare institutions. It facilitates adapting planning assistance in nursing within the family's available resources (CNA, 2013).

It provides better professional relationships with the family, as it is a less formal method and maintains the confidential relationship present in health services. It allows greater freedom for patients to express their concerns, because the time devoted to them is greater than the internal activities of the department allow. It reduces conflicts between the health team/family, as they suffer disruptions to their family, social and economic life blaming health teams. The influx of patients to emergency services decreases, which implies improving the quality of care provided to individuals who need care in emergency units.

Thus, it allows the nurse to educate for health at the place where usually the problem arises and to detect other health problems, giving nurses the possibility to plan with the family in real situations.

The nurse-patient therapeutic communication is a nursing intervention mode. The purpose is to achieve the highest level of well-being and possible independence in decisions and conducting daily activities (Bastos, 1998; Oliveira, et al, 2006).

One should never forget that the first concern of the nurse is the patient's well-being and that the relationship must be straightforward in order to calm anxieties and fears on the part of the patient/family. We can say that the nurse/patient relationship is fundamental and must be integrated in a therapeutic process in providing nursing care. Thus, the helping relationship is inseparable from the quality of nursing interventions.

2. Methods

The primary objective of the study is to analyze the degree of patient satisfaction towards the nursing care in the home.

The sample was non-probabilistic, intentional consisting of 44 patients receiving nursing care at home. Data such as the following were contained in the form: age, sex, marital status, residence, educational background, level of dependence (Katz Index), cohabitation and housing conditions. In order to assess patient satisfaction in nursing care at home, we constructed the scale of satisfaction of nursing care at home (EACED). The scale has the following dimensions with the respective indicators: Nurse/Patient Relationship (availability, interest, attention, help, trust); Nurse/Patient Communication (listening, informing, guiding, clarifying doubts); Health Education (importance of knowledge imparted, effectiveness of communication). The scale is also part of a question that evaluates the importance of home calls.

Each proposition of the Likert scale is assigned the score of as 5 very positive (very important) and the score of 1 as very negative 1 (not important). The propositions were considered important when they were awarded the scores of 5 and 4. The propositions whose scores were 3, 2 and 1 were negative. The sum of the amounts corresponding to the answers of patients, will allow us to conclude whether they were satisfied if the total is greater than 70% and not satisfied if the total is equal to or less than 70%. The scale is designed so that a final high score reflects a high satisfaction with nursing care in the home.

3. Results

In terms of age, the average is 76.59 years with a standard deviation of 10.44 years. Females (54.55%) predominate, and of these 25.00% were in the 68-78 age group, followed by 20.46% who were in the 78-88 age group. Males constituted 45.45%; of these 20.45% were in the 78-88 age group and 13.64% in the 68-78 age group.

Among the males, most were married, with 31.81%. With respect to females, the group that stood out were widows, with 29.55%. We emphasize that only 9.09% of the males are widowers and 18.18% of the women are married. In both groups 4.55% are single. The patients reside mostly in urban areas (65.91%) and the remaining 34.09% in rural areas. We highlighted the fact that 43.18% of our sample are illiterate, followed by the 29.55% who have four years of schooling. In males, with regard to schooling, 20.45% have primary education, 11.36% can read and write and 9.09% are in the group of illiterates. In women we found that 34.09% of the group are illiterate. Those who can read and write and have 4 years of schooling are also 9.09%.

Referring to the Katz index, the highest value, with 54.54%, corresponds to totally dependent patients. 22.72% of males are totally dependent, 9.09% are dependent and 9.09% are partially dependent patients. In relation to women, 31.82% are totally dependent, 9.09% are dependent and 6.82% are partially dependent with some functional autonomy.

The average degree of dependence is 14.54 with a standard deviation of 3.92. With regard to who they live with, 25.00% of males live with a spouse, while 40.91% females live with family members. 15.91% of the males reported living with relatives, while 9.09% of females live only with their spouse. Among the patients, 56.82% live with relatives and 34.09% with a spouse. We found one member of each group who resides with a housekeeper/neighbour and two patients, 4.54%, who live alone.

With regard to housing conditions, for 43.18% of the patients their house belongs to the family, 38.64% live in their own houses and 15.91% live in rented homes. As for females, 31.82% reside in a relative's house, 13.64% live in their own house and only 6.82% are in a rented house. With regards to males, 25.00% own their own homes, 11.36% are in homes belonging to family and 9.09% live in rented housing.

From the data obtained in relation to the house's characteristics, 93.18% have toilets and only 6.82% do not have a toilet. All homes, 100.00%, are equipped with electric lights but only 88.64% of patients enjoy indoor plumbing.

In in our overall sample where the respondents spend more time is in their room (70.45%), followed by 13.64% in the kitchen, 9.09% prefer to stay in the living-room and 6.82% of patients stay outdoors. For both sexes staying in their room is the most reported option, 31.82% of males and 38.64% of females.

With regard to the conditions where the patient spent the most time, the factors related to the presence of natural light, ventilation and room to move about, 97.37% had natural light and ventilation in the place where they stay during the day but only 88.64% stayed in a roomy place.

Patient satisfaction with regards to the relationship with nurses during house calls

The nurse/patient relationship was determined by the following indicators: availability, interest, attention, help and trust.

Regarding availability, 45.45% of patients think that the nurse is "very available" to them and 43.18% say "available". Regarding interest and attention, 50.00% of respondents attributed the maximum score and 40.90% positive minimum value. With regard to help, 47.73% consider the help given by the nurse "good" and 9.09% report it as "insufficient" to resolve their problems. As for the trust indicator, 63.64% "always" feel trust in the nurse and 9.09% only feel it "sometimes". The trust indicator obtained a score of 200, that is, 90.91%. We conclude that there is trust in the nurse. Attention and interest, both achieved 87.27%. Since they surpassed 70%, we consider that there is satisfaction with the action of nurses in home care.

As for the importance of the house calls, 75% respond that it is “very important” and 25% that it is “important”.

Patient satisfaction with the manner nurses communicate with them during house calls

The importance attached to how the nurse communicates with the patient was determined by the following indicators: informing, listening, guiding and clarifying doubts. The, the “informing” indicator was evaluated through three propositions. For the first, “While providing care, does the nurse tell you about what she will do?” There were 45.45% of patients who responded “always”. For the second question, “During the house call, does the nurse inform you about the evolution of your situation?” we obtained the same percentage. For the question, “On first contact does the nurse introduce herself by name?” 22.73% of patients responded “always”, but the same number of patients, 22.73%, answered only “sometimes”. It is worth noting that 31.82% answered “rarely” and 6.82% “never”. For the “listening” indicator, it is noteworthy that 43.18% of the patients respond with “always”. As for the “guiding” indicator, 36.36% answered “always”, while 27.27% answered “sometimes”. Regarding the “clarifying doubts” indicator, 50.00% answered “always” and 11.36% report “sometimes”.

The indicator “clarifying doubts” obtained a score of 85.91%. Regarding the “listening” and “guiding” indicators, they obtained 85.00% and 79.55%, respectively. We may also conclude that there was satisfaction in relation to these indicators.

The “informing” indicator was evaluated in three items. We achieved a high score, over 70.00%, so that we may also come to the conclusion that there was satisfaction with this dimension. However, one of the questions was negative, 63.18%, hence the terms have been analysed separately.

Thus, 31.82% report “rarely” and 22.73% answered “sometimes”. 18.18% of the males responded “sometimes”, and 20.46% of the females answered “rarely”.

For this dimension we also addressed the question, “During the treatment the nurse asks for the patient’s cooperation?” with a total of 36.36% of respondents answering “often” and 32.82% responding “always”. For men, the response was equal for both options, 18.18%; while among women the result was 18.18% “often” and 13.64% “always” for the item. 69.18% of the patients report that nurses often or always ask for cooperation during house calls.

Patient satisfaction in relation to how the nurse conducts health education during house calls

The importance attached to how the nurse conducts health education was determined by the following indicators: “importance of knowledge imparted” and “effectiveness of communication”. We found that the “importance of knowledge imparted” was evaluated through two propositions. For the first, “What do you think of the teaching?” 38.64% consider it “very important”, and 61.36% consider it “important”. On the question of, “Does the nurse guide you on how to proceed till the next visit?” 36.36% of patients reported “always” and 31.82% said “often”. For indicator “effectiveness of communication”, it is worth noting that 36.36% of patients said that the teachings are “very clear” and 61.36% answered that they are “clear”. With regards to “While visiting, the nurse expresses a readiness to answer questions,” 50.00% said “always” and 34.09% answer “often”.

Patients appear to be satisfied, with 87.73% of the maximum score. They are also satisfied in relation to how the nurse guides the patient/family on how to proceed till the next visit, with 79.54%.

“Effectiveness of communication” with a score of 190, corresponding to 86.36% of the maximum score for clarity of the situation and a score of 189, which corresponds to 85.90% in relation to knowledge imparted.

With regard to patient satisfaction there is a slight correlation, i.e., the higher the age, the higher the satisfaction; however, there is no statistically significant difference ($p = 0.37$). It should also be noted that there is a positive correlation between the age and dimensions of relationship ($r = 0.22$) and communication ($r = 0.10$), which means the higher the age, the higher the satisfaction with the relationship and communication. However there is a negative correlation relative to the health education dimension ($r = -0.03$) telling us that the higher the age, the lower the satisfaction with this dimension. From analysing the various dimensions that assess satisfaction, we found no significant statistical differences.

It is the 88 - 98 age group who were the most satisfied patients with regard to the nurse/patient relationship. This same age group were found to be the most satisfied patients regarding nurse/patient communication. It is, however,

the 68-78 age group who are the most satisfied patients with regards to health education. In the overall sample, it is the 88-98 age group are the most satisfied patients.

Overall, we verified that the male patients are more satisfied than females, although there is no statistically significant difference (p = 0.70).

Analysing each dimension separately, we found that men are more satisfied, although for each dimension the statistical difference is not significant: relationship (p = 0.88 and t = 0:14), communication (p = 00:49 ET = 0.69) and health education (p = 0.94 and t = 0:06).

It is the group for whom the Katz index is 6-8 who are the most satisfied patients with regard to the nurse/patient relationship. In this age group, moreover, we found the most satisfied patients in relation to health education. However, in the group where the Katz index is 16-18, we find the most satisfied patients with regard to communication. Overall, it is the group whose Katz index varies between 6 and 8 points that we find the most satisfied patients.

Regarding patient satisfaction by degree of dependency, there is a positive correlation. That is, the higher the degree of dependence, the greater the satisfaction, but the difference was not statistically significant (p = 0.73). It should be noted, however, that there is a very weak positive correlation between the degree of dependence and the dimensions of communication (r = 0.10) and health education (r = 0.03); the greater the degree of dependence, the higher the satisfaction with communication and health education. There is also a weak negative correlation with respect to the relationship dimension (r = -0.007) the higher the degree of dependence, the less satisfaction with that dimension. Reading through the various dimensions that assess satisfaction, we found no statistically significant differences (p = 0.73).

Depending on the degree of dependency, there were no statistically significant differences, although the mean values point to the most dependent group (16-18) was satisfied with regards to communication.

It is the married patients who observed greater satisfaction in the relationship dimension (31.09), while for communication the unmarried patients are the most satisfied (29.50). The married patients are also the most satisfied in relation to health education (17.18). Considering the group as a whole, we can say that the most satisfied group is the group of married couples with a score of 77.04.

Patients who are educated are more satisfied than the uneducated group, although there is no statistically significant difference (p = 0.94).

Analysing each dimension separately, we found that patients who are uneducated are more satisfied with the nurse/patient relationship (30.57). Regarding communication (28.93) and health education (17.25) educated patients are more satisfied. For any of the three dimensions, the statistical difference is not significant.

Patients who live in urban areas (76.31) are more satisfied than those living in rural areas (75.93), though the difference in satisfaction between the two groups is not statistically significant (p = 0.894 t = 0.133). Patients living in rural areas are more satisfied (30.60), although there is no statistically significant difference. Regarding communication (29.00) and health education (17.00) the patients who live in urban areas are more satisfied with no statistically significant differences (p = 0.894).

4. Conclusions

Based on gender and age, we observed that 54.55% are female. These results are in line with expectations, as women are more highly represented in our society. In our view, this is a natural phenomenon, and a consequence of the age factor and due to physiological and socio-economic factors women have a greater longevity. Looking at the age variable, we conclude that the average is 76.59 years and the 78-88 age group is the most representative. The results are in line with existing demographic knowledge about increased life expectancy in industrialized countries.

We also observed that 49.99% of the patients are married, although for females, widows are the predominant group, with 29.55%. Regarding residence, we found that 65.91% of patients live in urban areas. With regard to education, 43.18% of our sample are illiterate and 20.45% can only read and write. We believe that this result is in line with the situation in Portugal with regards to literacy, where a significant part of our older population is illiterate as a result of poor living conditions and lack of mandatory school attendance.

Referring to the Katz index we noted that the highest value in our sample, 54.54%, corresponded to totally dependent patients. When we related the Katz index with sex, we concluded that both groups had a very high degree

of dependence: males with 22.72% of totally dependent individuals, 9.09% dependent, and 9.09% partially dependent patients as well. In view of these results, we can conclude there is a significant number of fully dependent people, leading us to wonder if the current health services will have the capacity to respond to requests for help/support from patients/family. The number of dependent and partially dependent patients leads us to consider the risk they are taking if their condition worsens if timely prevention measures are not taken. Health centres should invest more in the area of rehabilitation.

Regarding cohabitation, the results show some differences such as: 25.00% of males lived with their spouse, while most females live with relatives, 40.91%. We were pleased to find these results because most of our sample is the 78-88 age group and in not living alone, it reduces the difficulties in meeting basic human needs, isolation, often caused by poor mobility, sadness and risk of depression.

With regard to housing conditions, we found that 43.18% of all patients lived in houses belonging to the family; 38.64% lived in their own home. As to whether they live in their own home, we think it is positive because they maintain a sense of belonging and independence, important factors for the elderly's socio-emotional balance. Most patients live in a family home, relating to the degree of dependence. This leads us to conclude that meeting daily support needs requires the elderly to make adjustments/concessions sometimes with respect to their lifestyle.

The data obtained in relation to the house's characteristics, we found that 93.18% had sanitary facilities and only 6.82% had no toilet. All units, 100.00% were equipped with electric lights and only 88.64% of patients enjoyed indoor plumbing. We think that owning a house with plumbing, electric lights and running water ensures a minimum of comfort and quality of life, especially for people whose average age is around 76 and already have some degree of dependence. It is appropriate that municipalities and parish boards united efforts to provide these needs.

In our sample overall, the place where respondents spent more time was in their room with 70.45% and 6.82% of the patients stayed outdoors. In both sexes the option to remain in their room was the most reported, 31.82% male and 38.64% female. We believe that the high rate of staying in the room was related to the high degree of dependency and the lack of capacity the family had to mobilize bedridden patients for lack of technical expertise, housing conditions and lack of support from other family members.

It is observed that 75.00% of respondents consider house calls very important helping to improve their health status. Many patients, however, report it would be convenient to increase the number of visits.

As for the nurse/patient relationship, the nurse establishes a helping relationship. We noticed that there was satisfaction in all indicators of this dimension. The "requests cooperation" is an attitude of exploration to see the extent of their knowledge and to involve carers in order to give theoretical and practical guidance.

In the nurse/patient communication aspect, we found that with regard to the "informing" item, we found all the rules were followed except one, "the nurse makes herself known by introducing herself by name." The "answers questions", "listening" are instruments used by nurses. Yet "guiding" also presupposes informing about the next visit and how long will the patient and family will be alone in providing care.

In effectiveness of communication, nurses must consider the kind of language, the amount of information and the patient's psycho-socio-cultural context.

With regard to patient satisfaction, in relation to how the nurse conducts health education during house calls, as measured by the indicators "importance of knowledge imparted" and "effectiveness of communication" on the question of "What do you think of the teachings?" 61.36% consider them "important" and on the question of "Does the nurse guide you on how to proceed till the next visit?" 36.36% respond "always". As for the question of "clarity of exposition" 61.36% respond it is "clear" and on the question of "availability to answer questions", 50.00% say they are "always" available.

We encountered a high overall satisfaction with the knowledge imparted as it allowed us to conclude that both professionals and patients are aware of the importance of teaching.

With regard to the three dimensions under study, it is in the 88-98 age group that we find greater satisfaction, but with no statistically significant difference.

In various dimensions it appears that male patients are more satisfied, although the difference was not significant.

If we look at the patients' satisfaction, it depends directly on the relationship, communication and health education, so that the relationship found seems understandable. It is the group of independent patients who find

more satisfaction in the aspects of relationship and health education. However, the most satisfied patients with regards to communication are totally dependent. In fact, several authors show that when there is therapeutic communication, it surpasses the intention to provide services – it is a way to help improve the patient's well-being (Basto, 1998; Pontes et al, 2008; Coelho, & Sequeira, 2014).

In our sample, the mean values indicate that the most dependent group is where the patients were satisfied in relation to communication.

There is no statistically significant difference between marital status and satisfaction, and between different dimensions and overall satisfaction. We found no statistically significant differences when compared with schooling.

Regarding communication and health education, the patients who live in urban areas are more satisfied and with relationship the patients living in rural areas are the most satisfied, the statistical difference was not significant.

There is patient satisfaction towards the relationship with the nurses during house calls for all indicators. There is satisfaction of patients due to the way the nurse communicates with them during house calls. This was assessed by the indicators: *informing, listening, guiding and answering questions*. On the question "she introduces herself by name", 31.82% responded "rarely".

There is patient satisfaction in relation to how the nurse conducts health education during house calls, as measured by the indicators "importance of knowledge imparted" and "effectiveness of communication".

The satisfaction of patients towards house calls is independent of marital status and level of education.

With 54.55% of our sample totally dependent, morbidity and mortality in this age group requires a review of the concepts and methods and changes in health care institutions in how to deal with the real problems the elderly face.

Work in the community must meet the population's needs and characteristics. It should be noted that the population utilising care is aging and for that reason there should be a greater commitment in providing care at home with a multidisciplinary team and with planning of care. House calls should conducted with a good bond and mutual aid among professionals, the patient and the family, which serve to establish effective communication, looking for changes in behaviour through education, clarifying doubts and always requesting the intervention of other technicians whenever required.

The home is a place where we transform by word, drama and listening situations that are sometimes very distressing, and it is up to whoever directs care to understand the irrationality (the unthinking) and realize that basic assumptions supporting the attitudes of patients/families in distress, favouring remaining at home and in the family and social environment, collaborating with families, strengthening their capacities and skills, giving them the necessary support and access and appropriate technical aids, seeking to create and promote conditions conducive to autonomy and well-being by stimulating participation in solving their own problems.

Promoting services and providing support equipment required by patients is essential.

Because of the awareness that patients/families have about the importance of education, it would help if with programmed teaching with patients/families were encouraged in this area, according to their needs and with practical examples wherever possible.

In short, the main responsibility of the nurse is to promote direct and indirect assistance to the individual, the family and the community. This assistance concerns health maintenance, promotion and protection, treatment of disease, rehabilitation and reintegration into the community. Of course, all of this presupposes establishing a relationship between the patient and the nurse to ensure that the person is seen as participating in the planning and implementation of nursing care for him or herself.

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