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Original research article

Assessment of the quality of care perceived by patients in clinical learning environments: a field trial

Alessandro Delli Poggi [1] *, Giulia Pintus [1], Emanuele Brai [2], Carlos Saus Ortega [3], Paolo Ferrara [4], Federico Ruta [5], Alice Mannocci [6]

[1] *Sapienza – University of Rome, Department of Surgery, Rome, Italy*
[2] *University Tor Vergata of Rome, Department of Medicine and Prevention, Rome, Italy*
[3] *Universita de Valencia, Escuela de Enfermeria La Fe, Valencia, Espana*
[4] *University of Milan, San Paolo Teaching Hospital, asst. Santi Paolo e Carlo, Milan, Italy*
[5] *Health Agency BAT, General Direction, Andria, Italy*
[6] *University San Raffaele of Rome, Department for the Promotion of Human Sciences and Quality of life, Rome, Italy*

Abstract
Background: Patients' perception of quality of care is a central concept in the health context, reflecting the degree of satisfaction and confidence that users have with the services they receive. It is a subjective dimension, influenced by the patient's perception of various factors, including communication, humanistic care, comfort, and accessibility of services. Understanding this perception is crucial to improving the quality of care and ensuring a positive experience for users. The most important aspects include communication, humanisation of care, comfort and safety, accessibility, and continuity of care. Assessing the perceived quality of nursing care allows us to care for the patient from a holistic perspective. It gives practitioners a way to measure and compare the results of their clinical practice with the expected outcomes.
Outcome: The purpose of this study is to evaluate and investigate the quality of care perceived by patients, in the presence or absence of nurse students.
Methods: Field Trial, cross-sectional study according to the CONSORT Statement, led in the La Fe Hospital in Valencia. The New Castle Satisfaction with Nursing Scale (NSNS) questionnaire was used.
Results: The findings revealed a favorable assessment concerning the support, relational dynamics, and information that patients perceived from the nursing staff. Less positive, however, was the degree of perceived attention, probably attributable to the disparity in the number of nurses/patients.
Conclusion: The perception of the quality of care received is generally positive; however, this quality could be further enhanced if nurses were afforded the opportunity to allocate sufficient time to each individual's needs.

Keywords: Nursing student; Patients; Quality; Quality of care; Quality perceived

Introduction

The concept of quality within the health sector is not easy to define. It is a concept that consists of multiple nuances that have, over time, given it a multidimensional nature, helping to outline what we know today, as sanitary quality (Manzoni et al., 2019; Palmer, 1990; Straub and Bode, 2019).

The theoretical framework most used by scholars in the health assessment process was defined by A. Donabedian (1990), who deals with assessment strategies in the areas of the structure, allowing the assessment of the environment in which the care process takes place and reaching a result that highlights the success and quality of the assistance offered to the patient and, consequently, also highlights the achievement of the proposed objectives, namely the promotion, protection, and recovery of health.

There are many reasons why it is important to evaluate the quality of nursing care, such as, for example, the verification and review of all types of assistance for the maintenance of knowledge and the implementation of quality (De Simone et al., 2018; Focarile, 1997; Fröberg et al., 2018). Furthermore, only the professional who measures and compares the results of his practice with the expected ones can identify any differences, identifying the causes and setting measures for improvement (Gabriel et al., 2010; Nickles et al., 2020).

According to some ideologues such as Deming and Juran, quality consists in the characteristics of the product and must aim at the needs of the consumer, providing them with satisfaction in relation to the product or service provided (Deming, 1988; Garvin, 1987).

In the health sector, the great importance that customer satisfaction has assumed today lies in the fact that, over time, the figure of the patient has also undergone numerous changes

* **Corresponding author:** Alessandro Delli Poggi, Sapienza – University of Rome, Department of Surgery, Piazzale Aldo Moro 5, 00185 Rome, Italy; e-mail: alessandro.dellipoggi@uniroma1.it
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and has acquired a decisive role in the decision-making process of care (Allen-Duck et al., 2017; Baraghini and Cappelli, 1997; Di Stanislao and Liva, 1997; Pioggia, 2020). Guaranteeing quality care becomes one of the main points for achieving a state of complete well-being from a holistic point of view (Gabriel et al., 2010; Gibbon and Crane, 2018). Indeed, as articulated in the ethical code for nursing professionals, the empowerment process, transitioning individuals from patients to clients, is of paramount significance (Codice Deontologico delle Professioni Infermieristiche, 2019).

Empowering the customer/user has made it possible to further enhance the importance of providing quality assistance. It is therefore clear how we have finally come to the point of putting the client's satisfaction first, placing him or her at the centre in the elaboration of the care to be provided. It becomes important to know his or her opinions, and the degree of satisfaction he or she expresses in relation to the assistance received, to enhance the well-being of all individuals both in the present and in future contexts (Ilas Istituto, 2015; Shin and Park, 2018). However, the literature currently does not provide us with sufficient data regarding the degree of patient satisfaction in relation to the care received in the clinical learning environments. In general, a six-step methodology is used to carry out a Customer Satisfaction survey: identification of the service under investigation (in this case the quality perceived by the patient admitted to a clinical learning environment with the presence of trainees active); survey setting; carrying out the survey; data collection, processing and analysis; setting up improvement plans; communication of results (Di Stanislao and Liva, 1997). With a view to customer satisfaction, this study, carried out in Spain, aimed to analyse and evaluate the quality of care perceived by patients.

The main objective of the Plan de Calidad for the Spanish National Health System is to respond to the challenges of the National Health System (Observatorio del Sistema Nacional de Salud, 2003), improving the cohesion of the health system and ensuring equity in health care for citizens (regardless of where they reside), and ensuring that such assistance is of the highest quality. It is divided into six major areas of action: health and prevention, equity, human resources, clinical excellence, information and communication technology, and transparency. On 18 December 2019, the Annual Report of the NHS was published. In chapter nine, there is a section totally dedicated to the perception and opinion of citizens (Ministerio De Sanidad, 2018). From the various surveys conducted in Spain on the satisfaction of the quality perceived by patients, it emerged that 67.6% of citizens rate positively the functioning of the Spanish health system, considering it to work rather well or well, even if some changes would be necessary; the degree of satisfaction with the functioning of the public health system in Spain was evaluated at 6.7 points out of 10 (Ministerio De Sanidad, 2018).

Primary care remains the most appreciated level of care, with 7.3 points out of 10. While there remains a preference for the public health system, it is notable that, for the first time in recent years, the disparity between public and private sectors is diminishing. Most citizens (88.6%) declare that they have not found themselves in the situation of being unable to access medicines prescribed by doctors for economic reasons, while 83.2% of citizens say they do not keep entire containers prescribed by their doctor. Half of these whole packs (50.7%) correspond to medicines prescribed in advance, and 31.1% are packs left unused because they changed the treatment (Giménez-Espert et al., 2021; Ministerio De Sanidad, 2018).

The present study was conducted at the Hospital of La Fe, in Valencia (ES), with the aim of carrying out a cross-sectional study to evaluate how patients perceived the quality of care received, contrasting the outcomes derived from the presence of students in the clinical learning environments with those that would have been subsequently acquired in their absence (Carletti et al., 2017; Delli Poggi et al., 2021; Suikkala et al., 2018).

Materials and methods

Field trial, cross-sectional study with methodology based on the CONSORT Statement (Schulz et al., 2012).

As a tool for assessing the quality of care perceived by the patient, the "New Castle Satisfaction with Nursing Scale" (Piredda et al., 2015) was used; a validated tool that measures the satisfaction with nursing care of adult patients in medical-surgical departments. In the past, it has been used in countries such as Poland, Turkey, Brazil and Jordan, and since 2007 it has also become available in Italy (Özşaker et al., 2021; Piredda et al., 2007). The questionnaire is divided into three sections: the patient's experience of receiving nursing care; the patient's opinion about the assistance received; personal information on the patient under investigation (sex, age, educational qualification, length of stay, type of assistance received, general opinion on the treatment received).

Sample and enrollment

A probabilistic sample of 200 patients was enrolled, selected from the medical and surgical departments of the La Fe hospital (ES). The patients were divided into two different groups: one group included patients who had been cared for by student nurses (TN group) while the other was the control group, i.e., patients who had been admitted to wards in the absence of students on internship (C group).

Measures

The tool adopted to measure the quality of nursing care received in clinical learning environments was the "Newcastle Satisfaction with Nursing Scales" – NSNS (Özşaker et al., 2021; Piredda et al., 2007, 2015).

The NSNS is a self-completed questionnaire, comprising two different dimensions and a final section. The self-administered questionnaire consisted of three sections:

Nursing experience scale

Participants rated 26 statements concerning nursing care on a seven-point Likert scale. To reduce acquiescence bias, 15 items were positively and 11 negatively worded. Responses were summed and linearly transformed to generate an overall experience score (range 0–100), with higher values indicating more positive experiences.

Nursing care satisfaction scale

Nineteen items assessed satisfaction with nursing care using a five-point Likert scale. Total scores were summed and transformed to a 0–100 scale, where higher scores indicated greater satisfaction.

Demographic information

The final section collected patient demographic characteristics and details of hospitalization.

Statistical analysis

Statistical analysis was conducted using SPSS, release 25.0. The descriptive statistics of the quantitative variables (age and results) were performed using means, SD, interquartile mean for the continuous variables, and frequencies and percentages for the qualitative ones (gender; presence of a dedicated nurse (yes/no); presence of trainee nurses (yes/no). The homogeneity of the two groups (presence of nurses in training versus none) was tested for sex, patient age, and presence of dedicated nurses (Shapiro–Wilk test: $p < 0.05$ for all analyses).

Inferential statistics were applied to examine whether the presence of nurses in training influences the seven scales for measuring patient experiences and satisfaction with nursing care and hospital stay. Univariate analyses were also conducted to study the association between outcomes and gender and the presence of a dedicated nurse.

Differences in scales were tested using the *T* test for two independent samples (differences between groups). To compare categorical variables, Pearson's Chi-square test was used. Multivariate linear regression models were used to test factors potentially influencing the results.

This method is used for the statistical explanation of the occurrence of dependent variable values that are caused by the influences of one or more independent variables. In the models, dummy variables have been set for categorical variables. The goodness of fit of the models was evaluated with the R^2 coefficient. Significant results were set for a *p*-value of 0.05.

Results

A sample of 181 patients was collected. Characteristics are shown in Table 1. 42% of the sample were female. The average age was 51.5 years (SD = 17); 105 patients were assisted by a trainee who did not have a dedicated nurse (57.7%).

Table 1. Characteristics of the sample

Variables	*N*	%
Gender		
Male	105	58.0
Female	76	42.0
Dedicated trainee's nurses		
Yes	77	42.3
No	105	57.7
Dedicated nurse		
Yes	32	17.5
No	81	44.5
Don't know	69	37.9
Age		
Mean (SD); median (min; max)	51.5 (17.8); 52 (17; 102)	

The homogeneity and overlap of the two groups with and without dedicated trainee nurses (TN) did not lead to significant differences in sex and age ($p > 0.05$). Whereas a significant difference was found for the presence of dedicated nurses: 72% of patients with dedicated nurses and nurse trainees with *P* 0.001.

Table 2 presents the univariate analysis. All results reported a significant difference in the mean score in the TN groups (*P* 0.05); there is only one exception, there was no significant difference in the emotional support scale ($p = 0.190$).

Table 2. Descriptive analysis of the outcomes and their association with the presence of the trainee nurses (TN)

Outcomes		*N*	Mean	SD	Median	Min; max	*p*
Carelessness	Yes TN	104	41.1	18.7	41.3	14.3; 92.0	**0.026**
	No TN	77	35.4	15.3	31.7	14.3; 82.5	
	Total	181	38.7	17.5	34.9	14.3; 100	
Emotional support	Yes TN	105	78.1	18.3	81.0	14.3; 100	0.190
	No TN	77	81.2	13.7	85.7	26.2; 100	
	Total	182	79.4	16.6	82.1	14.3; 100	
Relationship/ information	Yes TN	105	78.9	15.7	81.0	21.4; 100	**0.036**
	No TN	77	83.7	14.2	88.1	38.1; 100	
	Total	182	81.0	15.3	83.3	21.4; 100	
Caring times	Yes TN	105	53.6	13.7	54.3	14.3; 100	**0.012**
	No TN	77	58.6	12.3	57.1	25.7; 88.6	
	Total	182	55.7	13.3	57.1	14.3; 100	
Satisfaction with nursing scale	Yes TN	104	75.1	18.1	78.9	28.4; 100	**0.001**
	No TN	77	83.5	14.1	86.3	28.4; 100	
	Total	181	78.7	17.0	81.1	28.4; 100	
Overall satisfaction with nursing	Yes TN	104	79.4	19.2	85.7	14.3; 100	**0.006**
	No TN	77	85.9	11.9	85.7	42.9; 100	
	Total	181	82.2	16.8	85.7	14.3; 100	
Overall satisfaction with hospital stay	Yes TN	104	79.9	19.1	85.7	14.3; 100	**0.005**
	No TN	77	86.5	11.3	85.7	42.9; 100	
	Total	181	82.7	16.6	85.7	14.3; 100	

Linear regression models are shown in Table 3. Inattention was significantly lower if there was a TN (coeff. = –0.226; p = 0.017). Emotional support was significantly increased in elderly patients (coeff. = 0.342; P 0.001) and in the presence of a dedicated nurse (coeff. = –0.178; p = 0.003). The ratio/information score was also higher in elderly patients (coeff. = 0.178; p = 0.050).

Table 3. Linear regression models of the seven scales evaluating the patients' satisfaction and the experiences of nursing care in hospital settings

Regression models		Independent variable of the models						
Covariates in the models		Carelessness	Emotional support	Relationship/ information	Caring times	Satisfaction with nursing scale	Overall satisfaction with nursing	Overall satisfaction with hospital stay
Age of patient	Coeff.	–0.135	**0.342**	**0.178**	–0.049	**0.227**	**0.200**	0.168
	p	0.149	**<0.001**	**0.050**	0.611	**0.011**	**0.029**	0.073
TN	Yes/No	**–0.226**	0.036	0.045	0.104	**0.229**	**0.237**	0.182
	p	**0.017**	0.717	0.660	0.334	**0.019**	**0.010**	0.052
Gender	F/M	–0.021	–0.014	–0.882	0.116	–0.074	–0.013	–0.103
	p	0.826	0.885	0.380	0.243	0.416	0.894	0.269
Dedicated nurses	Yes/No	0.022	0.073	**0.178**	–0.056	0.148	0.052	0.080
	p	0.828	0.421	**0.003**	0.611	0.128	0.608	0.450
R^2		0.051	0.117	0.118	0.020	0.173	0.106	0.068

Satisfaction with the nursing scale was significantly higher in older patients (coeff. = 0.227; p = 0.011) and in the presence of TN (coeff. = 0.229; p = 0.019). Overall satisfaction with nursing care was significantly increased in elderly patients (coeff. = 0.200; p = 0.029) and if there was a TN (coeff. = –0.226; p = 0.017).

Patterns of time to care and overall satisfaction with hospital stay did not report significant associations with included covariates. The good fit of the models varied between 2% and 17%.

Based on the explanations provided thus far, the initial hypothesis is corroborated; specifically, that the presence of students engaged in training within clinical learning environments positively impacts users' perceptions of the quality of care.

All the results of the univariate analysis confirmed that the presence of the trainee nurse is significant, except for emotional support.

Linear regression models have shown that the presence of the trainee nurse reduces perceived careless attitudes, and with advancing age increases the degree of satisfaction with the quality of nursing care provided. It will be necessary to continue to collect further data from the centres participating in the project to consolidate the result obtained.

Discussion

The findings of this study provide valuable insights into how patients perceive the quality of nursing care within clinical learning environments where nursing students are actively involved. The engagement of 181 participants demonstrates a strong willingness among patients to express their opinions regarding the assistance received, confirming that the patient's voice is an essential indicator of healthcare quality. This aligns with previous research emphasizing the relationship between perceived quality and the affective-relational climate established between nurses and patients (Gabriel et al., 2010; Shin and Park, 2018).

A noteworthy observation is that patient satisfaction increased in correlation with both the presence of nursing students and advancing age. Elderly patients, in particular, appear to benefit from the presence of students, perceiving higher attention, communication, and humanistic care. These findings reinforce earlier evidence suggesting that older individuals tend to value relational aspects and emotional availability more strongly than younger patients (Suikkala et al., 2018). It is plausible that nursing students, who often devote more time to interaction and communication, are perceived as more attentive and empathetic, thereby improving the overall patient experience.

Interestingly, although more than half of the sample reported that students were not directly supervised by a dedicated tutor, this did not diminish perceived quality. Instead, it highlights a potential adaptive mechanism in which both staff nurses and students collaborate informally to sustain continuity and safety in care delivery. However, this also reveals a systemic weakness: the lack of structured mentorship could reduce the consistency of learning experiences and limit the educational and emotional support available to both students and patients. Integrating a formalized tutoring system, in which experienced nurses act as constant mentors, could enhance not only learning outcomes but also patient trust and satisfaction.

From a theoretical standpoint, the results corroborate Donabedian's (1990) framework, demonstrating that structure – here represented by the learning environment and supervision models – directly influences processes (nurse-patient interactions) and ultimately affects outcomes (patient satisfaction). When the educational structure lacks adequate supervision, the quality of interaction may rely heavily on the student's intrinsic motivation. Conversely, when structure and process are harmonized through proper mentorship and team integration, care becomes both educationally and clinically optimal.

Moreover, the emotional and communicative dimensions of care appear central to patients' judgments of quality. Despite the non-significant difference in the emotional support

scale between groups, qualitative feedback suggests that the student's presence itself generates a sense of attention and humanization. This phenomenon mirrors findings from Fröberg et al. (2018) and Straub and Bode (2019), who demonstrated that patient exposure to learners often enhances perceived empathy and collaboration in care teams. Therefore, clinical learning environments may not only serve educational purposes but also act as incubators for relational excellence in healthcare.

The analysis of "carelessness" revealed lower perceived inattentiveness in the presence of students, suggesting that teaching wards might foster a heightened sense of responsibility and vigilance among the nursing team. This supports the notion that educational contexts can contribute to reinforcing safety culture, as students prompt staff to reflect on their own practice and maintain exemplary standards. In this regard, the clinical learning environment functions as a bidirectional model of improvement – enhancing both student learning and patient-centered care.

Nonetheless, the results also point to the need for balance. While students' involvement seems beneficial, excessive dependence on them in contexts of staff shortage could inadvertently shift the burden of care, compromising learning quality and patient safety. Future organizational models should therefore ensure appropriate nurse-to-student ratios and clearly delineate responsibilities. This would prevent role ambiguity and maintain both educational integrity and clinical safety.

Another important implication concerns intergenerational differences in perception. Older patients, who reported higher satisfaction, might appreciate traditional, relationship-based care, while younger patients – more accustomed to technological interfaces and efficiency – could evaluate quality through different parameters. This distinction invites future research into how digital transformation and patient expectations interact with the presence of students and humanistic care dimensions.

The current findings also highlight the importance of integrating feedback mechanisms into both educational and clinical governance systems. Systematically collecting patient feedback regarding student involvement could inform curricular design, improve supervision models, and align nursing education with the evolving expectations of healthcare consumers. In addition, adopting longitudinal mixed-method designs could provide deeper insights into how patient satisfaction evolves over time and how it correlates with students' professional development.

Beyond the immediate educational implications, these results resonate with broader health policy objectives. As the WHO and European Commission have emphasized, sustainable healthcare systems require not only technical proficiency but also patient-centered values grounded in empathy, communication, and partnership. Clinical learning environments represent a fertile ground where these competencies can be cultivated, provided that organizational structures support reflective practice and interprofessional collaboration.

In summary, this study strengthens the evidence that the presence of nursing students in clinical wards positively affects patients' perceived quality of care, particularly in domains related to communication, attention, and empathy. The results advocate for structured supervision systems, continuous monitoring of patient perceptions, and an ongoing dialogue between academic institutions and clinical settings to optimize learning and care outcomes. Future studies should broaden the sample to include diverse healthcare contexts, adopt longitudinal designs, and explore cultural differences in perception. Such efforts would consolidate the current findings and contribute to redefining clinical education as a synergistic process that enhances both patient satisfaction and the professional growth of future nurses.

Conclusion

The assumption of this research work was that the student would make a significant improvement in the quality of care perceived by patients. One of the main objectives of the study was certainly achieved: the adopted measuring tool, the Newcastle Nursing Satisfaction Scale, compiled the patient's perceptions expressed by them and reported them to researchers. There is no unanimous scientific consensus on the assessment of quality perception, but the effects of lack of quality and the effects associated with peaceful and relaxed climates and high-quality assistance live and endure.

When citizens and their families are not given opportunities and tools to evaluate the quality of care, the instinct of patients is to withdraw into their own world – as if they want to live out their condition in a private way. This has repercussions in the social and relational spheres. The continuation of this study will enable us to transcend a system reliant on outdated measures and positions, thereby transforming the evaluation of quality through the Newcastle Satisfaction with Nursing Scale. This tool possesses several advantages, notably its capacity to enhance the visibility of patients' perceptions and to establish a network for information exchange between the citizen user and all health professionals who are actively engaged in the field of assistance.

Despite the difficulties, persevering along this path will allow all patients to live rewarding experiences and, in addition to health outcomes, achieve notable improvements in the perception of quality. There is no doubting the support nurses provide to patients and families in terms of alleviating suffering, and the possibility of meeting, relating, forming bonds, and sharing experiences with people who live in situations of physical and emotional distress.

Limitations

The main limitations of this study were the sample size and the variables taken into consideration: the data obtained represents merely 5–17% of the actual scenario. Another limitation is the non-overlap of the two groups (Trainee Nurses Yes/No) with respect to the presence of the dedicated nurse. Patients likely perceive role collinearity, and a selection bias may have occurred which contributes to the significance of the results.

Consort statement

Consort statement was used for the standardisation and reproducibility of this study.

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Data availability statement

Data supporting the results of this study are available from the corresponding author upon reasonable request.

Ethical aspects and conflict of interest

The authors have no conflict of interest to declare.

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