The patient experience of patient-centered communication with nurses in the hospital setting: a qualitative systematic review protocol

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Review question/objective

The objective of this systematic review is to synthesize the eligible evidence of patients’ experience of engaging and interacting with nurses, in the medical-surgical ward setting.

This review will consider the following questions:

- What are the expressed experiences of patients engaging and interacting in patient-centered communication with nurses?
- What are the beliefs, opinions and desires of patients, when engaging and interacting with nursing staff in terms of communicating in ways that meet the patients’ needs and wants?
- What factors do patients perceive influence (facilitate or prevent) patient-centered communication and their engagement and interaction with nursing staff?
- What are the experiences of patients of nurses listening to and responding to them within patient-centered communication with respect to their safety and experience of care?

Background

Communication is a way in which humans make sense of the world around them. Communication takes place as an interactive two-way process or interaction, involving two or more people and can occur by nonverbal, verbal, face-to-face or non-face-to-face methods. Effective communication is described to occur when the sender of a message sends their message in a way that conveys the intent of their message and then is understood by the receiver of the message. As a result of the communication from both the sender and the receiver of the message a shared meaning is created between both parties.
Communication can therefore be viewed as a reciprocal process. In the health care literature the terms communication and interaction are used interchangeably.\(^1\)

Communication failures between clinicians are the most common primary cause of errors and adverse events in health care.\(^3\) Communication is a significant factor in patient satisfaction and complaints about care.\(^4\) Communication plays an integral role in service quality in all service professions including health care professions.\(^2\)

Within healthcare, quality care has been defined by the Institute of Medicine as ‘care that is safe, effective, timely, efficient, equitable and patient-centred’.\(^5\)\(^(p.4)\) Patient-centered care is defined as ‘care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient’s values guide all clinical decisions. Patient centered-care encompasses the ‘individual experiences of a patient, the clinical service, the organizational and the regulatory levels of health care’.\(^4\)

At the individual patient level, patient-centered care is care that is ‘provided in a respectful manner, assures open and ongoing sharing of useful information in an ongoing manner and supports and encourages the participation of patients and their families’.\(^4\)\(^(p.5)\) Healthcare organizations that are patient-centered engage patients as partners and hold human interactions as a pillar of their service.\(^3\)

The deepening evidence base for principles and practice of patient-centered care has resulted in increasing recognition of, and greater focus on, the engagement of patients, and the value and benefit of patient engagement. Contemporary healthcare policy across the globe increasingly supports the engagement of patients as partners in all aspects of their own health care and also in systemic quality improvement. In 2005, the World Health Organization’s (WHO) World Alliance for Patient Safety established the Patients for Patient Safety program, to improve patient safety globally in collaboration with patient advocates across the world. As a global initiative, Patients for Patient Safety ‘believes that safety will be improved if patients are placed at the center of care and included as full partners’.\(^6\)

In 2011 the United States of America Department of Health and Human Services announced its commitment of one billion US dollars of federal funding\(^7\) under The Patient Protection and Affordable Care Act 2010\(^8\) and launched the Partnership for Patients initiative. The Partnership for Patients public-private consortium, which focuses on patient safety improvements and draws membership from federal government agencies and over 8000 health care providing organizations and individuals, views patients ‘as essential partners in improving safety and quality’\(^9\) and ‘their participation as active members of their own healthcare team is an essential component of making healthcare safer and reducing readmission’.\(^9\)

In Australia, as part of national health care reforms to improve access to care, the efficiency of care and public transparency of the performance and funding of health services, the Australian Health Ministers endorsed the 10 National Safety and Quality Health Service Standards (NSQHSS) in 2011 and the Australian Safety and Quality Goals for Health Care (The Goals) in 2012. The NSQHSS focus on partnerships with health consumers in their own care and treatment and also in health service planning, the design of care and service monitoring and evaluation.\(^10\) Standard 1 – Governance for Safety and Quality, and Standard 2 – Partnering with Consumers, are required to be integrated within all of the other eight Standards.

With patient safety and quality being core to the delivery of care the Safety of Care, Appropriateness of Care and Partnering with Consumers goals have been identified as the three areas that will make up the
goals over the next five years until 2017. The Australian Commission on Safety and Quality in Health Care, in providing further justification for the focus on these three areas, states:

They are relevant across all parts of the health care system and aim to focus attention on a small number of key safety and quality challenges which; have a significant impact on the health and wellbeing of individuals, and on the healthcare system as a whole, can be improved through implementation of evidence-based interventions and strategies, are amenable to national action and collaboration. 11

The third priority area of The Goals, Partnering with Consumers, reflects patient-centered care practice by ensuring ‘that there are effective partnerships between consumers and healthcare providers and organizations at all levels of healthcare provision, planning and evaluation’. Specifically, ‘Consumers and healthcare providers understand each other when communicating about care and treatment and health care organizations are health literate organizations”’. 11

As healthcare focuses on providing services that are patient-centered and methods to ensure this occurs, patients’ voice and experience of health care provision is increasingly being sought from an organizational quality improvement perspective. Patients are being surveyed on their healthcare experience across interpersonal areas such as being provided the opportunity by their health professional to ask questions, the level of involvement in their own care 4,12 and whether they were shown courtesy, treated with respect and listened to carefully by their health professional. 4,13

Surveys of patients’ satisfaction with their care are now being superseded by surveys of patient experiences of care. However, current methods used to collect and use information from patients about their care is often retrospective, provides inadequate real time data 14 and is not effective in creating action to produce change at the individual patient level.15-17 Methods which focus on including the patient and their information in real-time are considered by many to be crucial to the advancement of improved health outcomes and the reduced costs that are required of health care to be sustainable. 14

One such method is patient-centered communication.

The nurse-patient interaction is a core component of nursing science and high quality nursing care.18,19 Fleisher et al. contend that ‘the main intention of communication and interaction, in the health setting, is to influence the patient’s health status or state of well-being’. 1 As a profession, nursing predominately requires communicating with, and relating to, patients at the individual level. In the hospital setting nurses undertake many of their patient related duties in a face-to-face manner with the patient at the bedside and these moments can facilitate effective interaction to occur between the nurse and the patient, which is patient-centered. McCabe et al. state that patient-centered communication as “defined by Langewitz et al. as ‘communication that invites and encourages the patient to participate and negotiate in decision-making regarding their own care’.”19(p.42),20

However, qualitative studies by McCabe and Wellard et al, highlighted that nurses interact with patients only when performing administrative or functional activities 19 and nursing ‘practice was predominately task–orientated’.21(p.299) The outcome of these studies are supported by Maurer et al. in their report on the tools and strategies available to support patient and family engagement in the hospital setting. Maurer et al. identified that current strategies ‘are not attuned to patient and family member experiences of hospitalization”22(p.5) and that most tools and strategies were ‘more reflective of health professional and hospital views and the organization of their work’.22(p.5) The report identified a gap in the initiation of
engagement, which is not driven by the patients and families’ needs and preferences as they occur but by the ‘opportunities that the hospital makes available’.  

McCabe et al. also argue that nurses’ attending behavior, that is their ‘accessibility and readiness to listen to patients through the use of non-verbal communication’ requires that they have the underpinning elements of ‘genuineness, warmth and empathy’ all of which are components of patient-centered communication. McCabe et al. observed that ‘that nurses do not always communicate in a patient-centered way’.  

According to Fleischer et al. ‘The listening behavior in the way of listening and asking actually is the beginning of the nurse-patient communication relationship’. McCabe et al. state that the lack of recognition and support by healthcare organizations of the connection and subsequent importance of patient-centered communication in the provision of high quality care has promulgated a culture averse to patient centered communication and is a significant factor in reducing the value that nurses place on providing patient-centered communication to patients.  

It is apparent that tensions exist between service quality and patient-centered care principles and practice. The impact of this tension on care and the patient as an individual is reflected in the literature. McCabe et al. claim that the use of non-patient-centered types of communication can negatively affect a patient’s sense of well-being and security. Horvey et al. detail patient and family member experiences of not being listened to by their health care providers and describe the resulting consequences to be as severe as the death of the patient during their hospital stay.  

Opportunities for patients to engage and be listened to and be heard by their health care providers at the time they raise and address issues concerning their own care and safety whilst they are in hospital are often overlooked. Opportunities for patients to do so may often not be elicited or are missed by clinicians. The information patients can provide about their health status, condition and safety is under-utilised.  

Nursing science considers the participation of patients in their health care as central to the nurse-patient interaction; however audit and research have predominately focused on the evaluation of patient actions and behaviour. Therefore, nurse perceptions of patients have been a dominate focus rather than the experience of the patient. Tejero points out that nurse-patient interaction measurement instruments have focused on the nurse with ‘minimal or no consideration of the contribution of the patient’.  

McCabe et al. conclude that future ‘Patient focused studies may identify nursing behaviors that patients value highly in terms of patient-centered communication’. Given the focus of contemporary health care reforms and policy and the tension between policy and practice in patient-centered care delivery a systematic review on patient-centered communication from the patient’s perspective is warranted to investigate and provide the patients perspective and voice to patient-centered health care.  

An initial search of the literature has identified a systematic literature review conducted by Fleischer et al. on nurse-patient interaction and communication. This 2008 review described the use and definitions of the concepts of nurse-patient interaction and nurse-patient communication from conceptual and theoretical perspectives. However, it did not examine the direct interactions of patients and nurses from the perspective of the patient. An initial search of the Cochrane and the Joanna Briggs Libraries did not identify any systematic reviews on this topic. It is noted that within the Joanna Briggs Library a
systematic review by McCloskey et al. on “Patient, family and nurse experiences with patient presence during hand-off reports within hospitals” has been undertaken; however, this review related specifically to patient presence and did not address their experience of that encounter.

The absence of a systematic review on patient experiences of engaging and interacting with nurses at the point of care at the bedside is an identified gap in the literature. The reciprocal nature of communication warrants further understanding of patient communication with their nursing clinicians and the barriers and facilitators to patients’ engaging and interacting with nursing clinicians at the bedside in the hospital setting.

The aim of this qualitative systematic review is to synthesize the results of studies exploring patient experiences, beliefs, opinions and desires of engaging, interacting and communicating with nurses at the bedside setting during a hospital stay to allow major themes and concepts regarding the patient experience of patient-centered communication to be identified. A systematic review on the experiences of patients engaging and interacting with nurses will:

(1) further refine what is known about patient centered-communication at the bedside from the patient perspective;

(2) increase the understanding of health service management and nurses on facilitating and supporting patient-centered communication in the provision of quality patient-centered nursing care for patients; and

(3) promote a shift from communication with patients occurring only at times suited to the routine of the clinicians to the integration of proactive patient engagement and interaction throughout the continuum of a patients’ hospital stay.

Keywords

Patient-centered care; patient-centered communication; bedside; hospital setting

Inclusion criteria

Types of participants

The review will consider studies that include adult patients who are 18 years of age and older who have been admitted as inpatients to a medical-surgical ward.

Studies and texts presenting adult inpatients to all other hospital wards settings will be excluded. Maternity, emergency department, operating room, palliative and psychiatric ward settings will be excluded. Emergency department settings are excluded as they may not include patients that are admitted to hospital. Operating room settings are excluded because of the variations in the level of consciousness that may occur to patients. Maternity, palliative care and psychiatric patients because of unique needs of care required by these patients. Studies that include patients with cognitive disorders will also be excluded.

Phenomena of interest

This review will consider studies that investigate patient experience of engaging and interacting with nurses at the bedside in the hospital setting and the meaningfulness of that experience.
Types of studies

This review will consider studies that focus on qualitative data including, but not limited to, designs such as phenomenology, grounded theory, ethnography, action research and feminist research.

In the absence of research studies, other text such as opinion papers and reports will be considered.

Search strategy

The search strategy aims to find both published and unpublished studies. A three-step search strategy will be used. An initial limited search of MEDLINE and CINAHL will be undertaken followed by analysis of the text words contained in the title and abstract, and of the index terms used to describe article. A second search using all identified keywords and index terms will then be undertaken across all included databases. Thirdly, the reference list of all identified reports and articles will be searched for additional studies.

Studies published in English will be considered for inclusion in this review. Studies published from 1998-2013 will be considered for inclusion in this review. The commencing year of 1998 has been selected as it is anticipated that most studies that describe and investigate the patient experience occur after this date. This decision is based on the emergence of literature on patient safety and patient-centered care that have been integral to the formation of evidence for patient engagement and participation in health care.

The databases to be searched include:

PubMed
CINAHL
Embase
Dissertation abstracts (digital dissertations)

Initial keywords to be used will be:

Hospital care or acute care or point of care
Nurse or nurses or nursing
Patients or inpatient
Interact or talk or communicate or communication or relations or empathy or bonding or listening or voice or interpersonal or personal or caring
Patient-centered or patient-focused

Assessment of methodological quality

Papers selected for retrieval will be assessed by two independent reviewers for quality, validity and appropriates of methodology and method prior to inclusion in the review. Standardized critical appraisal instruments from the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI) (Appendix V) will be used. Any disagreements that arise between the reviewers will be resolved through discussion, or with a third reviewer.
Data collection

Data will be extracted from papers included in the review using the standardized data extraction tool from JBI-QARI (Appendix VI). The data extracted will include specific details about the phenomena of interest, populations, study methods and outcomes of significance to the review question and specific objectives.

Data synthesis

Qualitative research findings will, where possible be pooled using JBI-QARI. This will involve the aggregation or synthesis of findings to generate a set of statements that represent that aggregation, through assembling the findings rated according to their quality, and categorizing these findings on the basis of similarity in meaning. These categories will then be subjected to a meta-synthesis in order to produce a single comprehensive set of synthesized findings that can be used as a basis for evidence-based practice. Where textual pooling is not possible the findings will be presented in narrative form.

Conflicts of interest

No conflicts of interest

Acknowledgements

Dr Yifan Xue, Research Fellow, The Joanna Briggs Institute, Faculty of Health Sciences, The University of Adelaide
References


10. Australian Commission on Safety and Quality in Health Care (ACSQHC), Sydney. National Safety and Quality Health Service Standards. 2012.


16. Larsen D, Peters H, Keast J., Using real time patient feedback to introduce safety changes.


Appendix I: Appraisal instruments

QARI appraisal instrument

JBI QARI Critical Appraisal Checklist for Interpretive & Critical Research

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<th>Question</th>
<th>Yes</th>
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<td>1. Is there congruity between the stated philosophical perspective and the research methodology?</td>
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<td>8. Are participants, and their voices, adequately represented?</td>
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<td>10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?</td>
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Overall appraisal: Include □ Exclude □ Seek further info. □

Comments (Including reason for exclusion)

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Appendix II: Data extraction instruments

QARI data extraction instrument

JBI QARI Data Extraction Form for Interpretive & Critical Research

Reviewer ........................................... Date ...........................................

Author ............................................... Year ...........................................

Journal ............................................. Record Number ...........................................

Study Description
Methodology

Method

Phenomena of interest

Setting

Geographical

Cultural

Participants

Data analysis

Authors’ Conclusions

Comments

Complete ☐ Yes ☐ No ☐
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<tr>
<th>Findings</th>
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Extraction of findings complete: Yes ☐ No ☐