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Interpersonal Communication Strategies in Adult Inpatient Nursing Care and Patient Experience: A Scoping Review

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Abstract

Background: Nurses' interpersonal communication is a critical determinant of care quality, yet the optimal strategies for improving the adult inpatient experience have not been comprehensively mapped.

Aims: This scoping review aimed to map nurses' interpersonal communication strategies and evaluate their impact on the experiences of adult inpatients.

Methods: Guided by the Joanna Briggs Institute (JBI) framework and reported according to the PRISMA-ScR guidelines, a systematic search was conducted across EBSCOhost, PubMed, and Scopus for articles published between 2016 and 2026. Eligibility was determined using the Population-Concept-Context (PCC) framework, covering nurses and adult patients, interpersonal communication strategies, and acute inpatient settings.

Result: Six studies with heterogeneous designs met the inclusion criteria and were grouped into three themes: (1) structured communication and educational curricula (e.g., the teach-back method); (2) nonverbal adaptation and visual aids; and (3) communication directionality and patient involvement in decision-making. Structured communication approaches were associated with more favorable patient-reported satisfaction outcomes, whereas one-way communication was linked to a markedly higher risk of negative interactions (adjusted OR = 10.70); these preliminary patterns emerged from a small, heterogeneous evidence base.

Conclusion: This mapping suggests that interpersonal communication appears to be an important component of patient-centered clinical care. The available evidence indicates that structured strategies may enhance satisfaction, whereas systemic barriers such as heavy workloads and power imbalances can foster one-way communication. Given the limited and heterogeneous evidence, these patterns should be interpreted cautiously, and improving the patient experience is likely to require integrating structured communication with workload management to support patient-centered care.

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INTRODUCTION

Nursing care for adult patients in inpatient settings predominantly occurs through direct interaction and bedside care. The quality of care is determined not solely by the precision of clinical interventions, but also relies heavily on nurses' ability to communicate interpersonally and therapeutically. Effective communication facilitates the establishment of mutual trust and empathy between nurses and patients (Sassen, 2023). Furthermore, proficient communication supports clear information exchange while respecting patients' values and needs (Afriyie, 2020). Various verbal and nonverbal communication strategies are consistently associated with patient-centered outcomes, including enhanced satisfaction, improved perceptions of care quality, and overall well-being (Sharkiya, 2023). Patient satisfaction also tends to be higher when patients feel involved, receive prompt responses, and acquire clearly delivered education (Trotta et al., 2020). Accordingly, appropriate communication correlates with superior clinical outcomes, including

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accelerated recovery times (Barren et al., 2025) and elevated assessments of overall care quality (Xue & Heffernan, 2021).

Despite the critical importance of interpersonal skills, establishing genuinely patient-centered communication in clinical environments remains a complex endeavor (Kwame & Petrucka, 2021). In practice, therapeutic interactions are frequently impeded by systemic factors. High workloads and various organizational constraints can precipitate emotional exhaustion⁴⁷ among nursing staff (Mersha et al., 2023), simultaneously diminishing opportunities for nurses to engage in meaningful conversations with patients (Mielke et al., 2024). Conversely, the growing⁴⁵ reliance on health technology risks disrupting and degrading the quality of humanistic interactions between nurses and patients (Barren et al., 2025). Ultimately, the combination of emotional pressure on nurses and an unsupportive work environment can significantly diminish the effectiveness of communication strategies²² in inpatient wards (Yue et al., 2025).

These dynamics indicate that the relationship between communication and patient satisfaction is multifaceted. One study reported that the implementation of patient-centered communication does not automatically increase satisfaction scores, suggesting the influence of confounding factors (Sirera et al., 2024). Furthermore, evaluations within the literature are susceptible to misattribution bias; patient satisfaction is frequently attributed more to hospital infrastructure or non-nursing service amenities, thereby risking the overshadowing of the vital contribution of nurse-patient therapeutic interaction quality (Loureiro & Antunes, 2022). From historical perspectives to contemporary nursing, studies comprehensively mapping the impact of face-to-face interactions on the adult patient experience remain fragmented. Many publications focus instead on interprofessional communication, evaluate automated telenursing systems lacking direct interpersonal contact, or investigate specific populations outside the general medical-surgical context. Therefore, the integration of communication theories into nursing care practice still requires more directed and specific exploration (Högländer et al., 2022).

Prior reviews have approached nurse-patient communication from several angles but have left the adult inpatient interaction only partially mapped. Concept analyses have clarified what therapeutic communication is and how it relates to the nurse-patient relationship (Xue & Heffernan, 2021), while integrative and literature-based reviews have synthesized the broad determinants, barriers, and facilitators of patient-centered communication in nursing (Högländer et al., 2022; Kwame & Petrucka, 2021). Other syntheses have concentrated on single techniques or modalities, such as the teach-back method (Talevski et al., 2020) or the therapeutic use of touch (Buono et al., 2025), whereas still others have examined populations and settings that fall outside general adult inpatient wards for example, parents' satisfaction with the nursing care of hospitalized children (Loureiro³⁸ Antunes, 2022) or shared decision-making with older adults in primary care (Martínez-Aguayo³⁹ et al., 2023). What remains missing is a synthesis that treats direct, in-person interpersonal communication between nurses and adult patients in acute inpatient settings as its own object of study and maps how the specific strategies used relate to the patient experience. Critically, whereas Högländer et al. (2022) and Kwame & Petrucka (2021) synthesized the broad determinants and organizational barriers of patient-centered communication at a conceptual level, neither review catalogued or operationalized the specific, bedside-level communication strategies used by nurses against measured patient-experience outcomes; this operational, strategy-to-outcome mapping constitutes the key novelty of the present review. A dedicated scoping review is therefore warranted to consolidate this fragmented evidence and to make explicit which strategies have been studied, in which acute contexts, and with what reported effects.

Addressing these gaps, this scoping review establishes a clear focus on exclusively examining direct interactions between nurses and patients. This review aims to map, evaluate, and identify the implementation of interpersonal and therapeutic communication strategies in adult inpatient settings. Through a comprehensive synthesis of primary literature, this review anticipates clarifying the variety of communication strategies utilized and their subsequent impact on patient experience and satisfaction⁴⁸ levels within clinical nursing practice.

This review was guided by the following research question: What interpersonal communication strategies have been studied in direct nurse-patient interactions among adults in acute inpatient settings, and what patient-experience outcomes have been reported in association

with these strategies? This question directly informed the PCC eligibility criteria, search strategy, data extraction, and narrative synthesis described below.

METHOD

This study adopted a scoping review design to comprehensively explore and map the body of literature addressing interpersonal communication strategies within nursing care. The conduct of this review was guided by the Joanna Briggs Institute (JBI) methodological framework for scoping reviews (Peters et al., 2020), while the reporting process adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidelines to ensure transparency and systematic rigor (Tricco et al., 2018). Eligibility criteria were formulated using the Population, Concept, and Context (PCC) framework and were strategically established to keep the retrieved literature strictly aligned with the review objectives. Although the review followed the JBI methodological framework and PRISMA-ScR reporting guidelines, a formal review protocol was not registered in a public registry (e.g., PROSPERO, which does not accept scoping review protocols, or the Open Science Framework) prior to the conduct of the search; the absence of prospective protocol registration is acknowledged as a methodological limitation.

In terms of population, this review encompassed studies focusing on Registered Nurses (RNs) or nursing staff providing direct bedside care to adult patients (aged ≥ 18 years), whereas studies involving pediatric, neonatal, or psychiatric patients were excluded. Literature focusing on substance abuse or addiction populations and obstetric or maternity patients was also omitted, because such populations typically necessitate specialized clinical protocols and exhibit communication dynamics that are fundamentally distinct from general adult medical-surgical nursing care. With respect to the concept, the included literature comprised studies that explicitly mapped, evaluated, or implemented interpersonal and therapeutic communication strategies within nursing practice, with these strategies required to demonstrate a direct correlation with care outcomes such as patient satisfaction, the patient experience, or perceptions of nursing care quality. Conversely, studies were excluded if they focused on interprofessional communication (e.g., nurse-physician communication or nursing handovers), if care interactions were entirely technology-mediated without direct interpersonal contact (e.g., automated telenursing systems), or if patient satisfaction was solely attributed to hospital infrastructure and non-nursing services; methodological articles aimed purely at validating questionnaires or statistical measurement tools were likewise excluded.

Regarding context, the review was strictly limited to hospital inpatient settings or acute care environments. It exclusively included peer-reviewed primary research articles employing quantitative, qualitative, or mixed-methods designs, available in English and published within the last decade specifically from January 2016 to April 2026, corresponding to the final date of the literature search so that the included evidence reflects the most current trends in nursing communication practice.

A comprehensive and systematic literature search was conducted across three electronic databases extensively utilized in nursing and clinical care disciplines: PubMed, Scopus, and EBSCOhost. To optimize search sensitivity and specificity, the strategy integrated standardized medical terminology with targeted keywords, encompassing Medical Subject Headings (MeSH) in PubMed, controlled subject index terms, and free-text keywords queried across titles and abstracts. All search terms were connected using Boolean operators, with "OR" synthesizing synonyms within a single conceptual domain and "AND" intersecting the overarching concepts in adherence to the eligibility framework. The core conceptual domains queried were interpersonal communication, nursing care, adult inpatient settings, and patient satisfaction, and the full search strings are presented in Table 1. The three databases were selected to provide comprehensive coverage of the nursing and health-sciences literature, and the combination of controlled vocabulary with truncated free-text synonyms was intended to maximize the sensitivity of retrieval. All database searches were executed on 30 April 2026 by the first author (AW). The search syntax including field tags, Boolean operators, and controlled-vocabulary terms was adapted to the specific indexing conventions of each database, as shown in Table 1, and no supplementary search methods, such as citation tracking or hand-searching of reference lists, were performed; this is acknowledged as a

limitation in a later section. The search strategy was developed in accordance with the PCC framework and was reviewed by the two senior authors, both experienced nurse researchers, as part of their supervision of the review. All six studies that ultimately met the inclusion criteria were identified through these database searches, with none added from other sources (Figure 1).

Table 1. Literature Search Protocol

Database	Search String
PubMed	("Interpersonal Communication"[Mesh] OR "Nurse-Patient Relations"[Mesh] OR "communication strateg*" [tiab] OR "interpersonal communication*" [tiab] OR "therapeuti* communication*" [tiab] OR "relational communication" [tiab]) AND ("Nursing Care"[Mesh] OR "Nurses"[Mesh] OR "nursing care" [tiab] OR "nursing staff" [tiab] OR nurse* [tiab]) AND ("Inpatients"[Mesh] OR "adult inpatient*" [tiab] OR "acute care" [tiab] OR inpatient* [tiab]) AND ("Patient Satisfaction"[Mesh] OR "patient experience*" [tiab] OR "patient perception*" [tiab] OR "quality of care" [tiab]) AND ("2016/01/01"[PDat] : "2026/04/30"[PDat])
Scopus	TITLE-ABS-KEY ("communication strateg*" OR "interpersonal communication*" OR "therapeutic communication*" OR "relational communication*" OR "nurse-patient relation*") AND TITLE-ABS-KEY ("nursing care" OR "nursing staff" OR nurse*) AND TITLE-ABS-KEY ("adult inpatient*" OR inpatient* OR "acute care") AND TITLE-ABS-KEY ("patient experience*" OR "patient satisfaction" OR "patient perception*" OR "quality of care") AND PUBYEAR > 2015 AND PUBYEAR < 2027
EBSCOhost	(TI ("communication strateg*" OR "interpersonal communication*" OR "therapeutic communication*" OR "relational communication*" OR "nurse-patient relation*") OR AB ("communication strateg*" OR "interpersonal communication*" OR "therapeutic communication*" OR "relational communication*" OR "nurse-patient relation*") OR SU ("Interpersonal Communication" OR "Nurse-Patient Relations")) AND (TI ("nursing care" OR "nursing staff" OR nurse*) OR AB ("nursing care" OR "nursing staff" OR nurse*) OR SU ("Nursing Care" OR "Nurses")) AND (TI ("adult inpatient*" OR inpatient* OR "acute care") OR AB ("adult inpatient*" OR inpatient* OR "acute care") OR SU "Inpatients") AND (TI ("patient experience*" OR "patient satisfaction" OR "patient perception*" OR "quality of care") OR AB ("patient experience*" OR "patient satisfaction" OR "patient perception*" OR "quality of care") OR SU "Patient Satisfaction")

All citations identified through the search were exported into the Mendeley reference management software, and the selection process commenced with the removal of duplicate records retrieved across databases. Study selection then proceeded through screening against the predefined PCC eligibility criteria at the title and abstract level, with excluded records and the reasons for their exclusion recorded, followed by full-text retrieval and assessment of the reports that passed screening. To mitigate selection bias, two reviewers screened records independently; discrepancies were resolved through discussion to reach consensus, and a third reviewer was consulted as the final arbiter when necessary. The entire process, from initial identification to the final set of included articles, was delineated using a PRISMA-ScR flow diagram (Figure 1).

Data were extracted from all eligible manuscripts using a structured extraction form developed by the research team to map information congruent with the review objectives. For each article, the mapped data comprised the author(s) and publication year, country of origin, study design, participant or population characteristics, and the clinical setting in which nursing care was delivered. The team also extracted the data collection tools, methods used to measure outcomes for example, the Quality of Interactions Schedule (QuIS), the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, the Communicative Access Measures for Stroke (CAMS), and the Communication Assessment Tool for Nurses (CAT-N) together with granular details of the interpersonal communication strategies implemented as interventions or observational foci, and the principal findings on patient experience and satisfaction. Where an included study spanned more than one setting or population for example, a study conducted across both acute inpatient and home-care contexts, or one delivered by an interdisciplinary team that included nursing staff only the data pertaining to adult patients and nurses in the acute inpatient setting were charted and mapped, in keeping with the PCC eligibility framework; the corresponding acute-care subgroups are reported explicitly in Table 2. In particular, the study by Kagan et al. (2024), which involved an interdisciplinary stroke team, was retained because the evaluated intervention centered on direct nurse-patient communication (Supported Conversation for Adults with Aphasia) and because nursing personnel were directly and substantively involved in its implementation and delivery at the bedside.

In accordance with the JBI guidance for scoping reviews, this review did not undertake a methodological quality (risk-of-bias) appraisal of the included studies or a statistical meta-analysis; instead, the extracted data were analyzed descriptively and combined into a narrative synthesis. The mapping is presented in structured tables summarizing, first, the baseline study characteristics (study design, participant population, and clinical setting) and, second, the implemented interpersonal communication strategies and their corresponding measurement instruments. These

tabulations are augmented by a thematic narrative synthesis describing how the application of these strategies relates to patient satisfaction and experience in inpatient settings.

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RESULTS AND DISCUSSION

Results

Study Selection

The initial search across the three designated electronic databases yielded 281 records (Scopus, n = 194; PubMed, n = 61; EBSCOhost, n = 26). After 64 duplicate records were removed, 217 unique records were screened against the PCC eligibility criteria at the title and abstract level. Screening was performed by two reviewers working independently, with disagreements resolved through discussion and a third reviewer consulted as the final arbiter.

Of the 217 screened records, 209 were excluded as not meeting the eligibility criteria; the most frequent reasons were that a record did not map interpersonal communication strategies, involved a population or setting outside adult acute inpatient nursing care, employed an ineligible design (such as instrument-validation studies), or was not available in English. The remaining 8 reports were sought for full-text retrieval, of which 2 could not be obtained even through institutional database subscriptions and were therefore recorded as not retrieved. All 6 reports assessed at full text satisfied the eligibility criteria, with none excluded at this stage, yielding 6 primary research articles included in the review. This selection process is summarized in the PRISMA-ScR flow diagram (Figure 1).

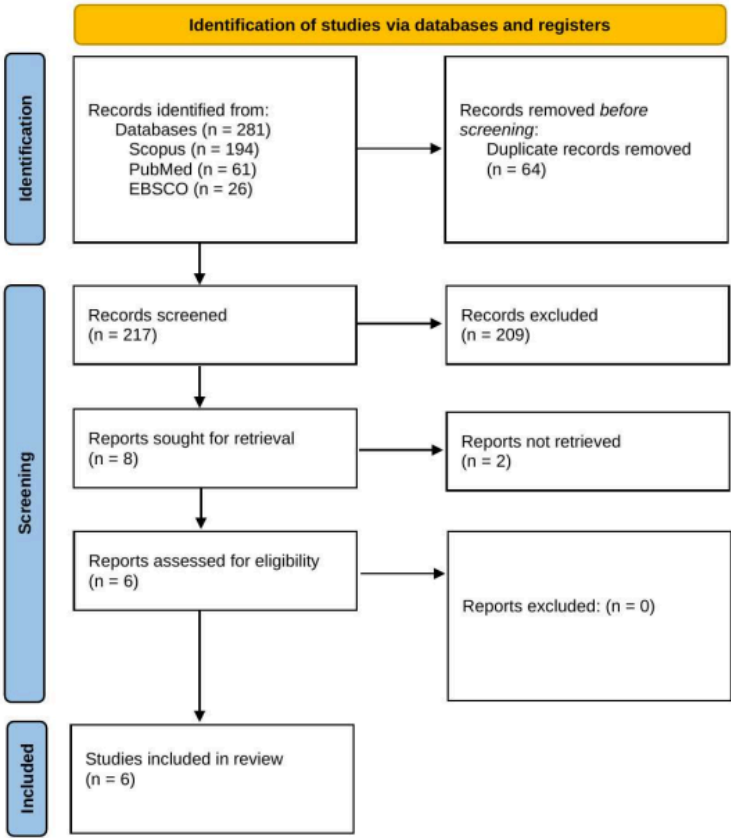


Figure 1. PRISMA-ScR flow diagram of the study selection process

Characteristics of the Included Studies

The six included primary research articles exhibited notable diversity in both their geographical distribution and methodological approaches. All studies were published within the last decade and were conducted across Europe, North America, and Australia. Specifically, the studies originated from Switzerland (Petry et al., 2023; Weber et al., 2024), the United States

(Allenbaugh et al., 2019), the United Kingdom (Barker et al., 2016), Canada (Kagan et al., 2024), and Australia (Harrison et al., 2025). Regarding research designs, three studies utilized quantitative approaches ($n = 3$), encompassing cross-sectional, descriptive observational, and pre-/post-intervention designs (Allenbaugh et al., 2019; Barker et al., 2016; Harrison et al., 2025). Two studies employed qualitative methodologies (Kagan et al., 2024; Petry et al., 2023), and one study implemented a mixed-methods design (Weber et al., 2024).

The sample sizes of the involved adult patients varied considerably, ranging from 34 to 422 individuals (Allenbaugh et al., 2019; Petry et al., 2023), whereas the number of nursing staff ranged from 19 to 85 personnel (Allenbaugh et al., 2019; Kagan et al., 2024). Notably, one observational study also recorded a substantial 1,168 direct communication interactions between nurses and patients (Barker et al., 2016). All investigations were conducted within hospital acute care settings. The specific unit contexts encompassed general medical-surgical wards (Allenbaugh et al., 2019; Barker et al., 2016; Harrison et al., 2025), geriatric and orthopedic units (Barker et al., 2016), as well as specialized units such as acute neurology (Weber et al., 2024) and stroke reactivation units (Kagan et al., 2024). Comprehensive details regarding the characteristics of each individual study are delineated in Table 2.

Table 2. Characteristics of the Included Studies

No	Author (Year)	Country	Study Design	Participants (N)	Clinical Setting	Data Collection Tool/Method
1	Allenbaugh et al. (2019)	USA	Quantitative (pre-/post-intervention)	RNs ($n=85$); resident physicians ($n=76$); adult patients ($n=422$ completed surveys)	General medicine wards	Direct observation (standardized communication checklist) and HCAHPS surveys
2	Barker et al. (2016)	UK	Quantitative (descriptive observational)	Adult patients ($n=133$, mean age 83 years); nursing staff ($n=1,168$ observed interactions)	Adult medical and surgical wards (geriatrics, urology, orthopedics)	Direct observation (Quality of Interactions Schedule [QuIS])
3	Petry et al. (2023)	Switzerland	Qualitative (constructivist grounded theory)	RNs ($n=49$ total, 28 in acute care); adult patients ($n=34$ total, 20 in acute care)	Acute care hospital and home care	Semi-structured individual interviews and focus groups
4	Weber et al. (2024)	Switzerland	Mixed-methods	Adult patients ($n=56$, mean age 75.0 years); RNs ($n=40$ eligible; $n=23$ pre-intervention, $n=21$ post-intervention)	Acute neurological ward	Investigator-developed questionnaires and open-ended text questions
5	Kagan et al. (2024)	Canada	Qualitative (process-oriented implementation study)	Interdisciplinary stroke team ($n=19$ total; including 1 RN, 2 RPNs, 2 nurse educators, and 14 allied health/management staff)	Acute care stroke and reactivation units	Communicative Access Measures for Stroke (CAMS) surveys, focus groups, interviews, and observations
6	Harrison et al. (2025)	Australia	Quantitative (cross-sectional survey)	Adult patients ($n=204$; 50.5% female, 55.9% aged ≥ 65 years)	Acute medical and surgical wards	Self-report survey (Communication Assessment Tool for Nurses [CAT-N])

Mapping of Communication Strategies and Patient Experience

The mapping of the included literature identified an array of interpersonal communication strategies implemented by nursing staff. Broadly, these strategies can be categorized into several distinct thematic approaches. Comprehensive details of the principal findings, including the specific instruments utilized to measure patient experience outcomes, are delineated in Table 3.

Structured Communication for Patient Education

A subset of studies evaluated interventions designed to facilitate the adoption of highly structured communication paradigms by nurses during patient education. Allenbaugh et al. (2019) implemented a concise communication curriculum anchored in health literacy principles. This encompassed the utilization of the teach-back method, the deliberate minimization of medical jargon, the distillation of educational content into one to three key takeaway points, and the deployment of specific elicitation questions, such as, “What questions do you have?”. The study reported a favorable change in patient satisfaction, reflected in an increase in top-box scores on the HCAHPS instrument from 65% to 75%. Furthermore, patients reported a higher frequency of nurses engaging in active listening and providing more comprehensible explanations.

Weber et al. (2024) evaluated a structured pedagogical approach utilizing informative leaflets as conversation guides during nurse-patient dialogues concerning fall risk education. This intervention strategically integrated enabling questions and culminated in high satisfaction levels, yielding a mean score of 5.3 on a 7-point scale. Additionally, the study noted that patients experienced a heightened sense of active involvement in fall risk prevention initiatives.

Nonverbal Communication and Assistive Tools

In scenarios where verbal communication is compromised, the literature underscores the imperative of nonverbal adaptations and the utilization of visual assistive aids. For instance, Kagan et al. (2024) evaluated the implementation of Supported Conversation for Adults with Aphasia (SCA). This methodology integrates yes/no cards, pictographs, and deliberate speech pacing. Such strategies empowered the nursing personnel within this interdisciplinary team to explicitly acknowledge patient competence and were associated with an improvement in the quality of information exchange.

Within the context of crisis isolation, a qualitative study by Petry et al. (2023) delineated nurses’ efforts to construct an “interactive space” through adaptive nonverbal techniques. These included bodily gestures, intensified eye contact, and the utilization of pen and paper to circumvent the physical barriers imposed by Personal Protective Equipment (PPE). Although these measures were effective in safely securing patients’ physical needs, their emotional and psychosocial requirements frequently remained unmet. Ultimately, the restriction of direct face-to-face interaction precipitated feelings of depersonalization among patients.

Bidirectional Communication and Patient Engagement in Decision-Making

The directionality of communication constitutes a pivotal factor correlating with the quality of the patient experience. Based on observations utilizing the QuIS instrument, Barker et al. (2016) reported that while 73% of staff-patient interactions were rated positively, 40% of patients still experienced at least one negative interaction. The study further demonstrated that one-way communication significantly elevated the likelihood of an interaction being perceived negatively by the patient (adjusted OR 10.70).

These findings are corroborated by Harrison et al. (2025), who evaluated the interpersonal behaviors of nurses. In their study, patients rated the aspect of respect favorably, as reflected by a score of 72.1% on the “Treated with respect” item. Conversely, patient engagement in shared decision-making emerged as the lowest-scoring domain (54.0%). Furthermore, Harrison et al. (2025) reported an inverse relationship regarding hospitalization duration: prolonged lengths of stay correlated with diminished patient ratings concerning information clarity and collaborative decision-making processes.

Table 3. Mapping of Interpersonal Communication Strategies, Measurement Instruments, and Principal Findings Regarding Patient Experience

Author (Year)	Interpersonal Communication Strategy (Concept)	Patient Experience Measurement Tool	Key Findings / Impact on Patient Experience
Allenbaugh et al. (2019)	Brief communication curriculum teaching health literacy best practices. Key techniques included the	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey	The intervention produced a moderate increase in communication scores. Patient satisfaction top-box ratings for overall communication

Author (Year)	Interpersonal Communication Strategy (Concept)	Patient Experience Measurement Tool	Key Findings / Impact on Patient Experience
Barker et al. (2016)	teach-back method, avoidance of medical jargon, limiting information to 1-3 key points, and using the specific prompt, "What questions do you have?". General staff-patient interactions categorized by directionality (one-way vs. two-way communication) and care content (e.g., personal care, routine communication, treatments).	(communication-specific top-box scores). Quality of Interactions Schedule (QuIS): an observation-based tool coding interactions as positive social, positive care, neutral, negative protective, or negative restrictive.	with nurses rose from 65% pre-intervention to 75% post-intervention. Patients reported higher frequencies of nurses listening carefully and explaining concepts understandably. While 73% of interactions were positive, 40% of patients experienced at least one negative interaction. One-way communication significantly increased the odds of a negative interaction (adjusted OR 10.70). Interactions involving two or more staff members simultaneously also increased the likelihood of negative ratings.
Petry et al. (2023)	Creation of an "interactive space" during crisis conditions using adaptive nonverbal techniques (e.g., gesturing, intense eye contact, using paper and pen) to overcome the physical barriers of personal protective equipment (PPE).	Qualitative semi-structured narrative individual interviews.	Patients felt their physical needs were safely met despite communication barriers. However, emotional and psychosocial needs were frequently unaddressed due to minimized face-to-face contact. Strict isolation protocols heightened feelings of depersonalization and psychological burden.
Weber et al. (2024)	Structured nurse-patient conversation guided by a specific communication aid (information leaflet). Nurses were trained to ask enabling questions and use tailored prompts to evoke behavior changes regarding individual fall risk-reduction.	Investigator-developed paper-and-pencil surveys measuring perceptions, overall satisfaction, and perceived involvement via a 7-point Likert-type scale.	Patients reported high satisfaction with the structured conversation (mean 5.3, SD 1.01) and felt highly involved in fall prevention (mean 5.2, SD 1.1). The strategy effectively supported patients in interpreting and managing their fall-related risks.
Kagan et al. (2024)	Supported Conversation for Adults with Aphasia (SCA): an evidence-based method using techniques such as yes/no cards, pictographs, and tailored pacing to reduce language barriers and highlight patient competence, implemented via eLearning and toolkits.	Communicative Access Measures for Stroke (CAMS) surveys, alongside qualitative focus groups, interviews, and observations.	SCA techniques enabled nurses to explicitly acknowledge patient competence and adjust pacing, improving information exchange. CAMS surveys indicated positive shifts in staff education and management support, facilitating the identification of previously unaddressed patient communication issues.
Harrison et al. (2025)	Evaluation of nurses' core interpersonal communication behaviors, focusing on domains such as demonstrating respectful care, active listening, providing clear explanations of care plans, and facilitating shared decision-making.	Communication Assessment Tool for Nurses (CAT-N): a 15-item self-report questionnaire using a 5-point Likert scale.	Patients perceived high standards of respectful care ("Treated me with respect" 72.1%; "Showed care and concern" 70.6%). Conversely, shared decision-making constructs scored lowest (e.g., "Involved me in decisions" 54.0%). Longer hospital stays were independently associated with lower ratings for shared decision-making and clear explanations.

Discussion

In interpreting these results, a distinction is maintained between evidence derived directly from the six included studies and explanatory mechanisms proposed on the basis of the broader communication and nursing literature. Because the included evidence is limited and heterogeneous, the wider literature is used to help explain observed patterns rather than to establish them, and such interpretive claims are attributed to their external sources throughout.

The review findings indicate that structured communication interventions are consistently associated with enhanced patient satisfaction across the two included studies that tested them. Allenbaugh et al. (2019) found that a brief, health-literacy-based curriculum incorporating the teach-back method, minimized jargon, and specific elicitation prompts raised top-box HCAHP communication scores from 65% to 75%, while Weber et al. (2024) reported high satisfaction (a mean of 5.3 on a 7-point scale) and a greater sense of involvement when nurses used an information leaflet to structure fall-risk conversations. Theoretically, this can be elucidated by the capacity of these interventions to counter clinicians' well-documented tendency to overestimate how much patients understand (Dickens et al., 2013; Kripalani & Weiss, 2006) and to diminish the information asymmetry between nurses as medical professionals and patients as lay individuals (Holcomb et al., 2022). In unstructured clinical interactions, nurses frequently presume that patients have comprehended the instructions or medical jargon delivered. Conversely, a structured communication curriculum compels nurses to decelerate the conversational pace, actively verify patient comprehension, and employ simplified clinical terminology. With the narrowing of this informational gap, patients' health literacy and capacity to recall critical medical information such as medication education during discharge (Marks et al., 2022) tend to improve, thereby fostering a sense of empowerment and validating their intellectual capacity. Consistent with this, recent randomized trials report that teach-back-based education improves patient satisfaction, discharge readiness, and symptom-related understanding across surgical, chemotherapy, and preoperative contexts (Gullet & Tastan, 2025; Gullu Gucuyener & Gulseven Karabacak, 2025; Shen et al., 2023).

Despite these substantial benefits, the literature also indicates that the implementation of structured communication is not invariably straightforward. The efficacy of instruments such as educational leaflets is not universal and is heavily contingent upon the patient's baseline health literacy. Patients with lower health literacy frequently report suboptimal satisfaction, even when provided with such materials (D'Souza et al., 2023). This nuance qualifies the leaflet-based strategy of Weber et al. (2024): although that intervention achieved high overall satisfaction, its benefit is likely to depend on how well the aid is matched to each patient's literacy level. This finding underscores that structured communication does not automatically translate to success; rather, it necessitates adequate training and managerial support to enable nurses to adaptively tailor communication strategies to the specific literacy profiles of individual patients (Talevski et al., 2020). This interpretation of literacy-dependent efficacy draws on the broader health-literacy literature and was not directly tested within the two included structured-communication studies.

Turning to nonverbal adaptation, the two included studies that examined it illustrate both its promise and its limits. Kagan et al. (2024) found that Supported Conversation for Adults with Aphasia using yes/no cards, pictographs, and deliberate speech pacing enabled nurses to acknowledge patient competence and was associated with an improvement in the quality of information exchange, whereas Petry et al. (2023) showed that when nurses improvised an "interactive space" with gestures, intensified eye contact, and pen and paper under the constraints of PPE, patients' physical needs were met but their emotional and psychosocial needs frequently were not, heightening feelings of depersonalization. Read together, these findings reveal a paradox in nonverbal practice that the wider literature helps explain. On the one hand, visual aids have proven effective in facilitating cognitive information exchange, particularly when patients experience communication barriers such as speech, language, or cognitive impairments, including aphasia (Brown & Thiessen, 2018; Chen et al., 2024). On the other hand, strategies relying solely on gestures are insufficient to fulfill patients' emotional needs, particularly in high-stress situations or crisis isolation necessitating the strict use of Personal Protective Equipment (PPE) (Alodan et al., 2024; Guetterman et al., 2024; Petry et al., 2023).

The emotional shortfall documented by Petry et al. (2023) where patients' physical needs were met but their psychosocial needs frequently were not can be understood through the holistic nursing paradigm; tellingly, even the structured SCA approach in Kagan et al. (2024) was associated

primarily with improvement in cognitive information exchange rather than in the affective dimension of care. A meaningful therapeutic bond is profoundly influenced by a reassuring presence, encompassing physical touch or therapeutic touch (Buono et al., 2025), as well as the nurse's ability to interpret micro-facial expressions to channel empathy (Babaii et al., 2021; Schlögl & Jones, 2020); indeed, empathic and positive communication has been associated with small but consistent improvements in patient outcomes such as pain, anxiety, and satisfaction (Howick et al., 2018; Smith et al., 2020). When these elements are diminished, or entirely obstructed by medical masks and other physical barriers, interactions tend to lose their emotional depth (Schlögl & Jones, 2020). Although gestures can assist in safely securing patients' basic physical needs, they do not inherently possess the affective power required to fully substitute genuine human connection (Guetterman et al., 2024). This impediment to expressing empathy can ultimately precipitate feelings of depersonalization in patients (Petry et al., 2023). These challenges are further exacerbated by the absence of standardized methods for implementing nonverbal communication in clinical settings, thereby limiting the efficacy of such interventions in alleviating patients' psychosocial distress (Caute et al., 2024). As with the interpretation above, this explanatory account of the emotional limits of nonverbal communication is drawn from the broader literature and extends beyond what the two included nonverbal-communication studies directly measured.

Furthermore, the mapping of interaction directionality across the included studies shows that one-way communication is tied to a poorer patient experience. Barker et al. (2016) found that one-way communication raised the odds of an interaction being appraised negatively more than tenfold (adjusted OR 10.70), while in Harrison et al. (2025) shared decision-making was the lowest-scoring domain, with only 54.0% of patients feeling involved in decisions. These two included studies document the association between one-way communication and a poorer patient experience but do not themselves identify its underlying causes. Notably, Harrison et al. (2025) also found that longer hospital stays were independently associated with lower ratings for shared decision-making and clear explanations, suggesting that sustained ward conditions, not only isolated encounters, may shape communication quality. These included-study findings may be interpreted in light of the broader nursing-workforce literature, which links high workloads and disproportionate nurse-to-patient ratios to a shift toward task-oriented rather than patient-centered care, with communication and educating patients among the activities most frequently left done under such conditions (Aiken et al., 2013; Högländer et al., 2022; Kwame & Petrucka, 2021; Ausserhofer et al., 2014; Ball et al., 2016; Griffiths et al., 2018; Cho et al., 2017; Driscoll et al., 2018; Appiah et al., 2023). This literature further suggests that sustained workload pressure may lead some nurses to default to one-way communication as a coping mechanism, and that imbalanced power dynamics can leave patients reluctant to voice their preferences, making shared decision-making difficult to enact in acute settings (Jerofke-Owen et al., 2022; Farrell et al., 2021; Warner et al., 2023); by contrast, primary care settings are reported to afford more time and space for bidirectional communication, underpinned by sustained collaborative relationships (Li & Chen, 2025; Martínez-Angulo et al., 2023). It is important to emphasize that these systemic mechanisms were not measured within the six included studies and represent an interpretation drawn from the wider literature rather than a direct finding of this review.

Relevance to the Community and Public Health

Although this review centers on interactions within inpatient wards, its findings carry indirect yet meaningful implications for the wider community and for public health promotion. Interpersonal communication is the mechanism through which clinical care is translated into knowledge that patients can act upon after discharge. When structured strategies such as the teach-back method and tailored education are associated with better patient understanding and recall of their care (Allenbaugh et al., 2019; Weber et al., 2024), patients may become better equipped to manage chronic conditions, adhere to treatment, and recognize warning signs at home which may support post-discharge self-management and potentially contribute to reduced preventable complications, thereby easing the burden of illness on families and the health system. Patients who leave hospital well informed can also act as conduits of accurate health information within their households and communities, contributing to broader community health literacy and to the aims of health-promotion movements such as the Healthy Living Community Movement (Gerakan

Masyarakat Hidup Sehat). Furthermore, communication approaches that deliberately include patients facing communication barriers, such as Supported Conversation for Adults with Aphasia (Kagan et al., 2024), advance health equity by extending clear health information to groups that are frequently marginalized in health dialogue. Viewed in this light, strengthening nurse-patient communication in acute care is not confined to the bedside; it forms part of a continuum that links hospital care to family caregiving, primary and community health services, and ultimately to a more health-literate, empowered, and healthier society.

Implications

The following implications are offered tentatively and are organized by their proximity to the evidence: they should be read as directions for practice and policy rather than as conclusions firmly established by the six included studies.

Evidence-supported implications (derived directly from the six included studies): the teach-back method and structured elicitation prompts (e.g., "What questions do you have?") were directly tested and associated with improved communication scores and satisfaction (Allenbaugh et al., 2019), supporting their incorporation into patient-education encounters; similarly, structured conversation aids such as information leaflets (Weber et al., 2024) and adapted nonverbal tools such as Supported Conversation for Adults with Aphasia (Kagan et al., 2024) were directly associated with improved patient involvement and information exchange, supporting their continued use with patients who have literacy or communication barriers.

Practice implications (the authors' interpretation, extending beyond direct testing in the included studies): nursing administration could embed these strategies into standard operating procedures (SOPs) for admission, patient education, and discharge so that verifying patient understanding becomes a routine, auditable step; institutions could also establish periodic, competency-based communication training and ensure practical communication aids are available on every ward; and communication quality could be monitored through explicit indicators, such as the communication-specific items of patient-experience surveys (e.g., HCAHPS or the CAT-N) and periodic observational audits.

23 Policy and research implications (based on the evidence gaps identified by this review): because the quality of nurse-patient interaction is plausibly shaped by the broader work environment a relationship this review could not directly test healthcare institutions and policymakers could periodically review nurse-to-patient ratios and workload, and future research should prioritize testing whether such system-level interventions measurably improve communication quality (Högländer et al., 2022).

Research contribution

This review contributes a focused evidence map of direct nurse-patient interpersonal communication in the adult inpatient context, a domain that has remained fragmented across the wider literature. By deliberately excluding interprofessional communication, fully technology-mediated care, and populations with fundamentally distinct communication dynamics (e.g., pediatric or outpatient settings), the synthesis isolates the specific strategies and systemic conditions that shape the adult inpatient experience. The resulting three-theme framework structured educational communication, nonverbal adaptation, and communication directionality offers researchers and nurse managers a consolidated reference for designing interventions and for identifying where current evidence is strongest and where it remains sparse.

10

Limitations

This review possesses several methodological strengths. The search strategy was executed comprehensively across three major electronic databases, mitigating the likelihood of omitting critical literature within the nursing domain; adherence to the PRISMA-ScR guidelines bolsters the transparency, rigor, and replicability of the study selection process; and the specific focus on interactions between nurses and adult patients yielded a highly targeted synthesis that avoids the ambiguity of conflating pediatric populations or outpatient contexts within a single review.

The small number of included studies (six) merits explicit contextualization. Rather than indicating an overly restrictive search, it largely reflects the deliberately narrow and specific scope

of this review: the Population–Concept–Context criteria³ were applied strictly, and the focus was confined exclusively to direct, in-person interpersonal communication between nurses and adult patients in acute inpatient settings. This deliberately excluded the substantially larger bodies of literature on interprofessional communication, fully technology-mediated care, questionnaire-validation studies, and pediatric, obstetric, psychiatric, or outpatient populations. The comprehensive search initially retrieved 281 records, yet only six met these tightly defined criteria an outcome that is better read as evidence of a genuine gap in primary research on this specific topic than as a shortcoming of the search alone. This scarcity is itself a key finding of the review, underscoring the need for more primary studies that directly examine nurse–patient communication strategies and their effect on the adult inpatient experience.

Nevertheless, certain limitations must be acknowledged. In alignment⁴¹ with the methodological parameters of a scoping review design, this study did not conduct methodological quality appraisals or risk-of-bias assessments of the included primary studies. Consequently, this review serves fundamentally as an evidence-mapping endeavor rather⁵ than a basis for drawing definitive conclusions regarding intervention efficacy. Furthermore, the restriction to English-language articles introduces the potential for language bias; innovative clinical communication strategies originating from non-English-speaking regions may therefore have been inadvertently excluded from this mapping. Similarly, no review protocol was registered in a public registry prior to the search, as noted in the Method section. In addition²¹ the search strategy was not formally peer-reviewed using a standardized instrument such as the Peer Review of Electronic Search Strategies (PRESS), and the reference lists of the included studies were not hand-searched; consequently, some relevant studies may not have been captured. A further consideration concerns the composition of the included evidence: one study (Kagan et al., 2024) was conducted with an interdisciplinary stroke team in which registered and practical nurses and nurse educators were part of, rather than the entirety of, the staff group. It was retained because it took place on nurse-manager-led acute inpatient stroke units and mapped communication strategies (Supported Conversation for Adults with Aphasia) that are directly enacted in nurse–patient interaction; nonetheless, its findings should be interpreted with this interdisciplinary context in mind and are not attributable to nurses alone.

Suggestions

Drawing upon the empirical gaps identified within this review, future research should be directed toward several priorities. First, rigorous studies utilizing experimental or longitudinal observational designs are warranted to evaluate the impact of system-level interventions such as the recalibration of nurse-to-patient ratios and initiatives aimed at redistributing ward power dynamics on the enhancement of bidirectional communication quality. Second, the development and clinical validation of standardized nonverbal communication modalities must be prioritized to mitigate the erosion of emotional depth and the concomitant risk of patient depersonalization, particularly in crisis isolation scenarios necessitating the stringent use of PPE. Third, cross-cultural studies are recommended to explore innovative communication strategies that may remain underrepresented within English-language literature. Fourth, future studies should specifically examine the effectiveness of communication strategies for adult inpatients with sensory impairments, such as older patients with presbycusis or severe hearing loss in acute care settings, a population whose communication needs were not addressed by any of the six included studies. Finally, to complement the narrative mapping function inherent to this scoping review, subsequent research should undertake systematic reviews and meta-analyses to quantitatively evaluate the clinical efficacy of structured communication frameworks in relation to objective patient recovery outcomes.

CONCLUSION

This scoping review mapped the interpersonal communication strategies used in direct nurse–patient interactions in adult inpatient settings and how they relate to the patient experience. The mapping revealed three recurring patterns: structured communication and patient education (e.g., the teach-back method), nonverbal adaptation and the use of visual aids, and the directionality

of communication together with patient involvement in decision-making. Across these patterns, structured approaches were generally associated with greater patient satisfaction, whereas one-way communication was associated with a higher likelihood of negative interactions. These signals are broadly consistent but rest on a small and heterogeneous body of evidence six studies differing in design, instruments, and clinical context and should therefore be read as preliminary patterns rather than established effects.

For practice, these patterns point toward embedding structured communication techniques and communication aids into routine nursing care, while recognizing that their effectiveness may be shaped by staffing and workload conditions. For research, priority should be given to testing system-level interventions, validating standardized nonverbal communication strategies, and undertaking systematic reviews or meta-analyses capable of quantifying the effect of structured communication on patient outcomes.

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AUTHOR CONTRIBUTION STATEMENT

AW conceptualized and designed the review protocol and search strategy; AW and MK conducted the study screening and data extraction; RS served as the third reviewer and solved discrepancies; AW performed the data charting and drafted the manuscript; MK and RS provided methodological supervision and critically revised the manuscript for important intellectual content; all authors reviewed and approved the final version of the manuscript.

AI DISCLOSURE STATEMENT

The authors used an artificial intelligence (AI) assistant (Claude, Anthropic) during the preparation of this work to support language editing, the formatting of the manuscript to the journal template, and the organization and formatting of the reference list. After using this tool, the authors thoroughly reviewed, verified, and edited all content including confirming the accuracy of every reference and its Digital Object Identifier (DOI) and take full responsibility for the content of the publication.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest financial, institutional, or personal that could have influenced the conduct of this study, the analysis of the data, or the preparation and publication of this manuscript.

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