

ORIGINAL RESEARCH

An assessment of nurse-patient therapeutic communication and patient satisfaction with nursing care in multiple healthcare settings: A study in Saudi Arabia

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ABSTRACT

Background: Effective therapeutic communication between nurses and patients is a fundamental element of high-quality healthcare. This study examines factors influencing therapeutic communication, including professional, contextual/situational, and patient-related aspects, while also assessing patient satisfaction with nursing care and the communication process.

Methods: Employing a correlational cross-sectional design, a sample of 80 nurses and 99 patients under their care was selected using purposive sampling methods. This study encompassed diverse healthcare settings in Hail, Saudi Arabia. Data were collected through two survey questionnaires: the Nurse-Patient Therapeutic Communication Questionnaire for nurses and the Patient Satisfaction with Nursing Care Quality Questionnaire for patients. The data analysis was conducted using SPSS v29.0, with findings presented using descriptive and inferential statistics.

Results: The professional dimension had a mean score of 5.56 ± 1.38 , the contextual and situational dimension had a mean score of 5.69 ± 1.42 , and the patient-related dimension had a mean score of 5.60 ± 1.46 . Age, education level, and workplace significantly influenced all dimensions (all $p < .001$). Patient satisfaction scores ranged from 1.87 to 5.00, with an average score of 4.07 ± 0.72 . Interestingly, patient satisfaction tended to increase with longer stays, $r(97) = .23, p = .024$, with the length of stay explaining 5.11% of the variability in patient satisfaction.

Conclusions: This study identifies three key dimensions—professional, contextual/situational, and patient-related—as significant factors in nurse-patient communication. Demographic variables, including age, education, and workplace, also played pivotal roles. Notably, patient satisfaction levels were consistently high and positively correlated with longer stays. To foster patient-centred care, it is recommended to prioritize customized communication training and sustain nurturing interactions throughout the patient's care journey.

Key Words: Communication, Therapeutic communication, Nurse-patient, Patient satisfaction

1. INTRODUCTION

Effective communication between nurses and patients is crucial to delivering high-quality healthcare and improving pa-

tient outcomes.^[1] A complex process that involves verbal and non-verbal cues,^[2] effective communication forms an essential foundation of all types of relationships,^[3] entailing

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active listening skills, empathy, respect, and easily understood language. The American Nurses Association^[4] recognizes the critical role of effective communication in achieving optimal healthcare outcomes for patients. As patient advocates, nurses must establish and maintain professional, therapeutic relationships with patients by using appropriate communication within the clinical setting, ensuring that patients are heard, valued, and involved in their care.^[5-7] Effective communication not only helps patients manage their conditions but also positively influences their physiological functions.^[8] Prior research has linked successful communication with improved patient satisfaction and well-being, as well as an increased level of professionalism and better quality of care.^[9,10] On the other hand, inadequate communication has the potential to cause health risks for patients, including medication errors and inadvertent harm.^[11]

The fundamental concepts of effective communication and the establishment of therapeutic relationships have long been an essential aspect of healthcare professional education, with nursing education specifically focusing on preparing reflective practitioners with effective communication skills.^[12] However, despite the emphasis on communication skills in nursing education, research suggests that nurse-patient relationships often fall short of expectations and that communication barriers exist between nurses and patients, which can lead to poor patient satisfaction, decreased health outcomes, and increased healthcare costs.^[13]

Language and cultural differences are particularly detrimental to effective communication. In Saudi Arabia, cultural and religious norms, as well as language barriers, are an especially salient topic^[14] due to the significant number of non-Saudi nurses working in hospitals, thereby further complicating nurse-patient interactions. Previous studies exploring the challenges faced by nurses in communicating effectively with their patients in Saudi Arabia have highlighted several significant barriers, including differences in language, religion, and culture between non-Saudi nurses and their Saudi patients.^[15-19] Notably, in 2021, the nurses working in Saudi Ministry of Health hospitals were 63% Saudi and 37% non-Saudi,^[20] while most patients in Saudi Arabia speak Arabic and have the same cultural values, norms, and religion. Additionally, cultural challenges exist within the Saudi community regarding the lack of male nurses, with the provision of care by female nurses to male patients potentially causing discomfort to Saudi men^[21] Such differences in gender and social norms can affect nurse-patient communication as well as patients' willingness to disclose information. Moreover, prior research on the demographics of Saudi nurses has revealed their notable lack of professional experience.^[22] Additional barriers identified in previous literature include

nurses' inadequate education, training, and skills;^[23,24] time constraints, busy schedules, workload, and insufficient time for interaction with patients;^[23] and the lack of adequate resources, such as interpreters and appropriate communication aids.^[14]

The unique qualities possessed by nurses can impact their ability to communicate effectively and can hinder the successful establishment of the nurse-patient relationship. As individual personality traits and personal preferences can influence the relationships formed through communication, healthcare professionals must recognize and acknowledge their own biases, while also adopting a level of cultural sensitivity.^[9] Furthermore, it is important to understand that communication is influenced by the specific situation and context. Thus, the characteristics of the patient, the healthcare organization, and the interactions with other professionals all play a role in shaping communication dynamics.^[9] Nursing research must take all these factors into consideration, as they can have an impact on the care provided to patients. Consequently, nurses should be able to recognize and understand the various elements involved in their communication, as well as the roles they assume in different situations and contexts.

Effective communication between nurses and patients is essential for ensuring that patients receive appropriate care, understand their diagnosis and treatment options, and feel supported and heard throughout their healthcare journey. Furthermore, restricted interactions between nurses and patients have adverse effects on the nurse-patient relationship, with potentially adverse consequences for patient safety and diminished levels of patient satisfaction. Patients' satisfaction with their nurses' communication process is an important aspect of healthcare quality, with Peplau's theory of interpersonal relations in nursing highlighting the significance of nurse-patient relationships for patients' experiences. According to Peplau, nursing research should prioritize patients' needs as well as their perceptions of nursing care.^[25] The prior literature has found mixed results concerning patients' satisfaction with nursing care. For instance, nurses' interpersonal and efficient communication skills greatly increased patient satisfaction in an interventional study conducted in Ethiopia.^[26] A review study in Saudi Arabia^[14] found that nearly half of the surveyed patients expressed dissatisfaction with the communication provided by expatriate nurses. More than half of the patients in a Riyadh hospital expressed dissatisfaction with the language fluency of their nurses and the adequacy of discharge information provided to them.^[27] On the other hand, patients were satisfied with Saudi nurses with whom they shared a language, culture, and religion in a previous study,^[28] although they also expressed low

satisfaction rates regarding discharge instructions and keeping the patients' families informed. In Al Momani and Al Korashy's^[29] study, the patients displayed high levels of satisfaction with aspects related to communication, expertise, and care, although their satisfaction levels were lower when it came to receiving education on self-help and experiencing empathy from nurses. Several studies on expatriate nurses have shown that certain communication practices rely on non-verbal approaches due to a lack of a common language, which often leads to the intended meaning being misunderstood.^[14]

The primary objective of this research is to examine the various factors contributing to the successful implementation of therapeutic communication, particularly within the framework of patient-centred care and satisfaction. While some studies have investigated nurse-patient communication in Saudi Arabia, most focused on identifying barriers to effective communication,^[14, 16-19] and there has been limited attention on other factors that may also influence communication dynamics. This study aims to bridge this gap by taking into account the broader context in which communication occurs. It hereby incorporates Peplau's theoretical foundation, which acknowledges that communication is not a simplistic one-way exchange between patient and nurse. Instead, it recognizes communication as a dynamic process that is influenced by several factors, including professional considerations, situational circumstances or contextual elements, and the unique characteristics of the patients themselves. By adopting this approach, this study aims to evaluate various factors influencing therapeutic communication, in addition to assessing patient satisfaction with both nursing care and the communication process. Furthermore, this research seeks to illuminate the impact of demographic factors on the communication process.

2. METHODS

2.1 Study design

This study employed a cross-sectional approach using survey questionnaires to collect data on nurse-patient therapeutic communication and patients' satisfaction with nursing care quality. It was conducted in multiple healthcare settings in Hail, Saudi Arabia, to capture a diverse range of perspectives and experiences.

2.2 Participants

The participants for this study were meticulously recruited from four government hospitals located in Hail, Saudi Arabia. The selected hospitals are well-established institutions with a bed capacity of approximately 200 to 300 beds, making them ideal settings for gathering a diverse and representative

sample. The study participants included both nurses and patients. To ensure a comprehensive representation of different healthcare settings, specialities, and patient demographics, a purposive sampling strategy was adopted. The study participants consisted of 99 patients and 80 nurses. The sample size was determined based on the number of nurses and patients on each ward.

The participants, both nurses and patients, were recruited from the inpatient wards through the assistance of research coordinators at each hospital, who visited the wards on a daily basis, covering different shifts, to ensure comprehensive data collection. After providing a clear explanation of the study objectives, informed consent was obtained from nurses who were willing to participate. The nurse sample included nurses from medical, surgical, and emergency wards. Eligibility criteria for nurses included having at least three months of clinical experience and currently working in a direct patient care role. Patients who had received care from a participating nurse were chosen randomly and given the questionnaire once the objectives of the research had been thoroughly explained and their informed consent had been acquired. Eligibility criteria for patients included being over the age of 18, having a minimum of a two-day hospital admission, possessing stable health conditions, demonstrating the capacity to assess their experiences, and expressing a willingness to take part in the research. All participants provided informed consent and received guarantees regarding the confidentiality of their information. The questionnaire, created using the Google Forms platform, was made accessible to all participants via a provided link.

2.3 Instrument

Data collection involved the distribution of two self-administered survey questionnaires: the Nurse-Patient Therapeutic Communication Questionnaire for nurses and the Patient Satisfaction with Nursing Care Quality Questionnaire for patients.

The Nurse-Patient Therapeutic Communication Questionnaire was developed based on Peplau's theoretical foundation by Granados-Gómez et al. (2022).^[9] The questionnaire is divided into three dimensions: 1) professional, 2) contextual and/or situational, and 3) patient. These dimensions reflect the complex interactions involved in healthcare settings and allow for a comprehensive assessment of nursing care. The questionnaire consists of 49 items and uses a Likert-type scale with responses ranging from 1 to 7, where 1 represents "not important at all" and 7 represents "very important". This scale allows respondents to rate the importance of each item in relation to their nursing practice. The Cronbach's alpha coefficient score is 0.90, indicating high internal consistency.^[9]

The Patient Satisfaction with Nursing Care Quality Questionnaire was created by Laschinger et al. (2005)^[30] to measure patient satisfaction with nursing care during hospital stays. The Arabic version of the questionnaire was used after obtaining permission from Albashayreh et al. (2019).^[31] It has 17 self-reported items, divided into two domains: satisfaction with provided care and satisfaction with the provided information. Patients rate their satisfaction on a 5-point Likert scale ranging from poor to excellent. Scores for each domain are summed and averaged to give a single value for each patient, and are reported as a composite score or domain-based score. The PSNCQQ-Ar has an excellent overall Cronbach's alpha coefficient of .96 and similar results across different hospital units.^[31]

2.4 Data analysis

The data was analysed using SPSS v29.0. The reliability and validity of the study constructs were ascertained through Cronbach's alpha and the Kaiser-Meyer-Olkin test. In addition, Analysis of Variance (ANOVAs) and *t*-tests were used to explore group differences and variations, while Pearson's correlations unveiled the associations between the variables. Statistical significance was established using a confidence level of 95%, where a *p*-value less than .05 indicated significance.

3. RESULTS

3.1 Nurse-patient therapeutic communication

3.1.1 Sociodemographic characteristics

For the Nurse-Patient Therapeutic Communication Questionnaire, the sample size was 80, of which 66.3% (*n* = 53) were female and 42.5% (*n* = 27) were male, while 42.5% (*n* = 34) were 20 to 29 years old, 51.2% (*n* = 41) were 30 to 39, and 6.3% (*n* = 5) were 40 to 49. In terms of educational attainment, 30% (*n* = 24) had a diploma, 62.5% (*n* = 50) a bachelor's, 6.3% (*n* = 5) a master's, and 1.3% (*n* = 1) fell into the "other" category. Only 3.8% (*n* = 3) had less than 1 year of experience, while 32.5% (*n* = 26) had 1 to 5 years of experience, 36.3% (*n* = 29) had 5 to 10, 18.8% (*n* = 15) had 10 to 15, and 8.8% (*n* = 7) had over 15 years of experience. The majority, at 60% (*n* = 48), spoke Arabic as their first language, while 16.3% (*n* = 13) spoke English, 8.8% (*n* = 7) Hindi, 13.8% (*n* = 11) Tagalog, and 1.3% (*n* = 1) Tamil. When asked about their religious affiliation, 30% (*n* = 24) said Christianity, 5% (*n* = 4) Hinduism, and 65% (*n* = 52) Islam. Exactly 20% (*n* = 16) of the sample worked in Hospital (1), 26.3% (*n* = 21) in Hospital (2), 28.7% (*n* = 23) in Hospital (3), and 25% (*n* = 20) in Hospital (4).

3.1.2 Professional items

The professional items' scores ranged from 1.00 to 7.00 with a mean of 5.56 (SD = 1.38). Professional item scores were highest for 40 to 49 year olds (M = 6.12, SD = 1.22), followed by 30 to 39 year olds (M = 5.94, SD = 0.99), and 20 to 29 year olds (M = 5.01, SD = 1.63), $F(2, 77) = 5.120$, $p = .008$. Professional items scores were highest for those with an "other" degree (M = 6.75), followed by those with a diploma (M = 5.90, SD = 0.92), a bachelor's degree (M = 5.58, SD = 1.32), and a master's degree (M = 3.51, SD = 2.26), $F(3, 76) = 5.079$, $p = .003$. Professional items scores were highest for those with over 15 years of experience (M = 6.16, SD = 0.57), followed by those with 10 to 15 years (M = 6.05, SD = 0.92), 5 to 10 years (M = 5.67, SD = 1.27), 1 to 5 years (M = 5.18, SD = 1.70), and those with less than 1 year of experience (M = 3.92, SD = 0.36), $F(4, 75) = 2.616$, $p = .042$. The professional item scores were highest for those working at Hospital (1) (M = 6.36, SD = 0.19), followed by those at Hospital (4) (M = 6.21, SD = 0.67), Hospital (2) (M = 5.57, SD = 1.81), and those at Hospital (3) (M = 4.42, SD = 1.12), $F(3, 76) = 11.934$, $p < .001$ (see Table 1).

3.1.3 Contextual and/or situational items

The contextual and/or situational items' scores ranged from 1.00 to 7.00 with a mean of 5.69 (SD = 1.42). Contextual and/or situational item scores were highest for those aged 40 to 49 years (M = 6.09, SD = 0.94), followed by those aged 30 to 39 years (M = 5.61, SD = 1.54) and those aged 20 to 29 years (M = 5.21, SD = 1.73), $F(2, 77) = 5.120$, $p = .008$. Contextual and/or situational item scores were highest for those with an "other" degree (M = 6.79), followed by those with a diploma (M = 5.96), a bachelor's degree (M = 5.77, SD = 1.24), and a master's degree (M = 3.31, SD = 2.47), $F(3, 76) = 6.300$, $p < .001$. Contextual and/or situation item scores were highest for those working at Hospital (1) (M = 6.49, SD = 0.23), followed by Hospital (4) (M = 6.31, SD = 0.68), Hospital (2) (M = 5.56, SD = 2.08), and Hospital (3) (M = 4.70, SD = 0.99), $F(3, 76) = 8.906$, $p < .001$ (see Table 2).

3.1.4 Patient items

The patient items' scores ranged from 1.00 to 7.00 with a mean of 5.60 (SD = 1.46). The scores were higher for females (M = 5.84, SD = 1.32) than for males (M = 5.11, SD = 1.62), $M = 0.73$, 95% CI [0.06, 1.40], $t(78) = 4.626$, $p = .032$. The patient item scores were highest for those 40 to 49 years of age (M = 5.97, SD = 0.94), followed by those 30 to 39 (M = 5.95, SD = 1.30), and those 20 to 29 (M = 5.12, SD = 1.59), $F(2, 77) = 3.426$, $p = .038$. The patient item scores were highest for those with an "other" degree (M = 6.00), followed by those with a diploma (M = 5.91, SD = 1.29), a bachelor's degree (M = 5.62, SD = 1.38), and a

master’s degree ($M = 3.80, SD = 2.14$), $F(3, 76) = 3.166, p = .029$. The patient item scores were highest for those working at Hospital (1) ($M = 6.49, SD = 0.28$), followed by those working at Hospital (4) ($M = 6.25, SD = 1.02$), Hospital (2) ($M = 5.50, SD = 1.94$), and Hospital (3) ($M = 4.50, SD = 1.00$), $F(3, 76) = 10.519, p < .001$.

Table 1. Professional, contextual/situational, and patient items by demographic characteristics

Demographic Characteristics	Professional Items		Contextual Items		Patient Items	
	M ± SD	p-value	M ± SD	p-value	M ± SD	p-value
Gender		.113		.139		.032
Male	5.21 ± 1.46		5.36 ± 1.62		5.11 ± 1.62	
Female	5.73 ± 1.32		5.85 ± 1.28		5.85 ± 1.32	
Age Group		.008		.024		.038
20-29	5.01 ± 1.63		5.21 ± 1.73		5.12 ± 1.59	
30-39	5.94 ± 0.99		5.61 ± 1.54		5.95 ± 1.3	
40-49	6.12 ± 1.22		6.09 ± 0.94		5.97 ± 0.94	
Education Level		.003		< .001		.029
Diploma	5.9 ± 0.92		5.96 ± 1.09		5.91 ± 1.29	
Bachelor’s	5.58 ± 1.32		5.77 ± 1.24		5.62 ± 1.38	
Master’s	3.51 ± 2.26		3.31 ± 2.47		3.8 ± 2.14	
Other	6.75 ±		6.79 ± -		6 ± -	
Work Experience		.042		.121		.096
Less than 1 yr	3.92 ± 0.36		3.93 ± 0.19		4.4 ± 0.4	
1-5 yrs	5.18 ± 1.7		5.53 ± 1.69		5.2 ± 1.74	
5-10 yrs	5.67 ± 1.27		5.66 ± 1.38		5.64 ± 1.34	
10-15 yrs	6.05 ± 0.92		6.11 ± 1.07		6.04 ± 1.28	
15+yrs	6.16 ± 0.57		6.2 ± 0.73		6.46 ± 0.62	
First Language		.983		.962		.935
Arabic	5.54 ± 1.37		5.69 ± 1.44		5.52 ± 1.49	
English	5.54 ± 1.69		5.61 ± 1.72		5.54 ± 1.79	
Hindi	5.54 ± 1.42		5.99 ± 1.18		5.99 ± 1.29	
Tagalong	5.61 ± 1.26		5.53 ± 1.28		5.72 ± 1.14	
Tamil	6.4 ±		6.21 ± -		6.07 ± -	
Religious Affiliation		.569		.699		.489
Christianity	5.8 ± 1.13		5.81 ± 1.14		5.88 ± 1.1	
Hinduism	5.7 ± 1.42		6.11 ± 0.71		5.78 ± 1.29	
Islam	5.44 ± 1.49		5.6 ± 1.57		5.45 ± 1.61	
Place of Work		< .001		< .001		< .001
Hospital (1)	6.36 ± 0.19		6.49 ± 0.23		6.49 ± 0.28	
Hospital (2)	5.57 ± 1.81		5.56 ± 2.08		5.5 ± 1.94	
Hospital (3)	4.42 ± 1.12		4.7 ± 0.99		4.5 ± 1	
Hospital (4)	6.21 ± 0.67		6.31 ± 0.68		6.25 ± 1.02	

3.1.5 Validity

Exploratory factor analysis was used to determine the construct validity of the questionnaire. The Kaiser-Meyer-Olkin test was 0.90 with Bartlett’s sphericity of $\chi^2(1176) = 5075.020; p < .001$. These values suggest that the factor analysis was appropriate. Three factors were confirmed as explaining 79.136% of the total variance.

3.1.6 Reliability

The Cronbach’s alpha value of the Professional Items was 0.972. For the contextual and/or situational items, it was 0.965. For the patient items, the Cronbach’s alpha was 0.968. These values indicate the reliability of each construct.

3.2 Patient satisfaction questionnaire

3.3 Patients' sociodemographic characteristics

The sample size was 99, whereby 35.4% (n = 35) of the questionnaires were filled out by someone else and 64.6% (n = 64) were filled out by the patient. Meanwhile, 47.5% (n = 47) were male and 52.5% (n = 52) were female, with a mean age of 35.82 years (SD = 14.24). Education levels varied, with 9.1% (n = 9) having no formal education, 32.3% (n = 32) a high school diploma, 12.1% (n = 12) a diploma, 44.4% (n = 44) a bachelor's degree, and 2% (n = 2) a postgraduate degree. The patients had a mean of 2.39 (SD = 1.85) hospitalizations and a mean length of stay of 18.25 (SD 71.82) days. When asked about their health condition before entering the hospital, 3% (n = 3) were unsure, 22.2% (n = 22) stated very bad, 34.3% (n = 34) bad, 31.3% (n = 31) moderate, 6.1% (n = 6) good, and 3% (n = 3) excellent. At 62.6% (n = 62), most had a shared room, while 37.4% (n = 37) had a private room. When it came to others accompanying them, 56.6% (n = 56) claimed another person had. Finally, 65.7% (n = 65) know their nurses' names (see Table 2).

3.3.1 Patient satisfaction

The overall satisfaction score ranged from 1.87 to 5.00 with a mean of 4.07 (SD = 0.72). When asked about the quality of nursing care during their stay, 6.1% (n = 6) said fair, 23.2% (n = 23) good, 20.2% (n = 20) very good, and 49.5% (n = 49) said excellent. Based on the nursing care received, 2% (n = 2) strongly disagreed with recommending the hospital, 6.1% (n = 6) somewhat disagreed, 19.2% (n = 19) somewhat agreed, 16.2% (n = 16) agreed, and 56.6% (n = 56) strongly agreed. Satisfaction scores were highest for Hospital (2) (M = 4.89, SD = 0.23), followed by Hospital (1) (M = 4.57, SD = 0.19), Hospital (4) (M = 3.70, SD = 0.65), and Hospital (3) (M = 3.54, SD = 0.48), $F(3, 95) = 47.147, p < .001$. Satisfaction scores generally increased with patient length of stay, $r(97) = .23, p = .024$, with length of stay accounting for 5.11% of the variability in patient satisfaction. Patients with a private room had higher satisfaction scores (M = 4.26, SD = 0.77) than those with shared rooms (M = 3.96, SD = 0.67), $M = 0.30, 95\% \text{ CI } [0.01, 0.59], t(97) = 2.021, p = .046$. Those who had someone accompanying them also had higher satisfaction scores (M = 4.23, SD = 0.70) than those who did not (M = 3.86, SD = 0.70), $M = 0.36, 95\% \text{ CI } [0.08, 0.65], t(97) = 2.560, p = .012$. Those who knew their nurses' names had higher satisfaction scores (M = 4.19, SD = 0.73) than those who did not (M = 3.83, SD = 0.64), $M = 0.36, 95\% \text{ CI } [0.07, 0.66], t(95) = 2.437, p = .017$ (see Table 2).

3.3.2 Validity

An exploratory factor analysis was used to determine the construct validity of the questionnaire. The Kaiser-Meyer-Olkin test was 0.91 with Bartlett's sphericity of $\chi^2(105)$

= 930.102; $p < .001$. These values suggest that the factor analysis was appropriate. Two factors were confirmed as explaining 60.857% of the total variance in patient satisfaction.

3.3.3 Reliability

The Cronbach's alpha value of the patient satisfaction construct was 0.937. This value indicates the reliability of the construct.

Table 2. Patient satisfaction scores by patient demographics

	Patient Satisfaction M	Patient Satisfaction SD	p-value
Person Filling out Survey			.899
Someone else	4.08	0.75	
The patient	4.06	0.71	
Gender			.001
Male	4.31	0.74	
Female	3.85	0.64	
Education Level			.198
None	4.08	0.75	
High school	4.11	0.61	
Diploma	4.49	0.64	
Bachelor's	3.93	0.80	
Postgraduate	3.83	0.05	
Hospital			< .001
Hospital (1)	4.57	0.19	
Hospital (2)	4.89	0.23	
Hospital (3)	3.54	0.48	
Hospital (4)	3.70	0.65	
Health Condition Before Admission			.533
Unsure	4.51	0.32	
Very bad	3.95	0.62	
Bad	4.14	0.82	
Moderate	4.05	0.65	
Good	3.78	0.93	
Excellent	4.51	0.85	
Hospital Accommodation			.046
Shared room	3.96	0.67	
Private room	4.26	0.77	
Is someone accompanying you?			.012
No	3.86	0.70	
Yes	4.23	0.70	
Do you know your nurse's name?			.017
No	3.83	0.64	
Yes	4.19	0.73	
Age	35.82	14.24	.057
Previous Hospitalizations (n)	2.39	1.85	.906
Length of Stay (days)	18.25	71.82	.024

Satisfaction scores generally increased with patient length of stay, $r(97) = .23, p = .024$, with length of stay accounting for 5.11% of the variability in patient satisfaction (see Table 3).

Table 3. Patient satisfaction correlation matrix

	<i>p</i> -value
1. Satisfaction	
2. Length of Stay (days)	.226*

*. Correlation is significant at the .05 level (2-tailed).

4. DISCUSSION

This study comprehensively examined the multifaceted factors influencing nurse-patient therapeutic communication. It also evaluated the levels of patient satisfaction regarding their nursing care experience, encompassing communication exchanges and the adequacy of information provided. Notably, the study found that three key dimensions—professional, contextual/situational, and patient-related—were significantly important for respondents. Age, education level and place of work had a significant effect on all domains. Another important finding is that patients' satisfaction with their nursing care was high, with satisfaction scores generally increasing with the length of their stay.

The professional component items highlight the multifaceted approach that nurses take to ensure empathetic and effective communication with patients, considering verbal and nonverbal cues, adapting to patient needs, and promoting understanding and comfort. Age had a significant effect on the professional items, whereby the scores were highest for 40 to 49-year-olds and those with over 15 years of experience. Those groups might have accumulated a more nuanced understanding of patient dynamics and patient needs over the years. The alignment of these findings with the study by Moir et al.^[32] suggests a consistent pattern. This confidence might stem from their familiarity with a broader spectrum of patient scenarios and the communication skills they have refined over their careers.

In the current study, age had a significant effect on the contextual dimension, which assesses challenges of patient communication imposed by the work context, the influence of the clinical unit, and time management. Age had a significant effect on the contextual items, whereby the scores were highest for 40 to 49-year-olds, which might be attributed to a combination of factors. This group might be more adept at striking a balance between experience and adaptability, allowing these participants to effectively navigate the complex interplay of work contexts, clinical unit dynamics, and patient communication. Their ability to manage these intricacies could arise from their familiarity with evolving healthcare practices and a potentially strong network of professional relationships. Additionally, it has been identified that adequate practical experience can enable nurses to surmount communication obstacles and participate in effective

therapeutic communication.^[1,33]

For the patient components, which assessed factors such as patients' appearance, culture, decision-making, lifestyle and situation, age had a significant effect, with 40 to 49-year-old nurses also having the highest scores, along with female gender. This suggests that this demographic might possess a heightened cultural sensitivity and an attuned ability to understand diverse patient backgrounds and preferences. Their life experiences and maturity might contribute to their proficiency in tailoring communication to individual patients' lifestyles, and situations.

The education level was one of the factors that significantly affected all domains in this study. Nurses with a master's degree scored the lowest in all three dimensions while those with a diploma scored the highest, implying that a higher educational level does not necessarily translate into superior communication skills. This could be due to a range of factors, such as differing focuses in educational programs or an increased emphasis on theoretical knowledge over practical communication training.

In the current study, we found that language and religious affiliation did not show a statistically significant association with nurses' communication, as perceived by the nurses. This differs from the majority of previous research conducted in Saudi Arabia, where language, religious beliefs, and cultural differences were consistently identified as significant barriers to effective communication.^[15-19] It is worth noting that our findings also contradict those of the study by Amoah et al.^[23] in Iran, which recognized language as an obstacle to successful therapeutic communication.

With regard to patient satisfaction, a significant proportion of patients (69.7%) reported that they found the quality of nursing care provided by nurses to be either good or excellent. Impressively, a substantial number of respondents (56.6%) strongly agreed that they would recommend the hospital based on the exceptional nursing care they had received. These findings are consistent with other studies conducted in Saudi Arabia. In a Riyadh hospital, Atallah et al.^[27] reported a significant level of satisfaction (86%) regarding the quality of nursing care among patients. Similarly, in a more extensive patient sample, Alasad et al.^[34] also identified a high degree of satisfaction with nursing care. Similar findings were found in Jordan and Pakistan^[35,36] while moderate satisfaction was revealed among Ethiopian patients.^[37] However, in several previous studies,^[8,23,38] a notable portion of the patients expressed dissatisfaction primarily because of the nurses' lack of attention, which emerged as a prevailing obstacle to effective communication within their research.

It is noteworthy that there were variations in satisfaction based on certain factors. Notably, male patients seemed to express higher levels of satisfaction, contradicting the findings from Alasad et al.^[34] where female patients were shown to be more satisfied with nursing care. Conversely, other studies Alsaqri^[21] And Karaca & Durna^[39] found that gender had no significant impact on patient satisfaction. Additionally, the patients in this study who had the privilege of staying in private rooms during their hospital stay tended to express higher levels of satisfaction. The presence of a companion during their hospitalization also appeared to be associated with increased satisfaction levels. Moreover, an interesting trend emerged in that patients who were familiar with their assigned nurses' names appeared to experience a higher degree of satisfaction. This suggests that establishing a personal connection and knowing the caregivers by name might contribute to a more positive patient experience, possibly indicating improved communication and a sense of personalized care.

In the present study, satisfaction scores tended to rise as the patient's length of stay increased, a trend consistent with the findings of Alsaqri's^[21] study. This can be attributed to the extended interaction time between patients and healthcare providers. Longer stays provide more opportunities for nurses to build rapport, address concerns, and ensure that patients receive consistent and comprehensive care. Patients may develop trust and a sense of familiarity with the nursing staff during this time, contributing to higher satisfaction levels.

The patients in Hospital^[2] had the highest satisfaction rate, which may be linked to a range of factors. This hospital might have a more patient-centred approach, better-trained staff, or improved facilities that enhance the overall patient experience. However, this research uncovered no notable variations in patient satisfaction based on factors such as education level, a pattern consistent with the results of Shinde and Kapurkar.^[40] However, this finding contrasts with the findings of Karaca & Durna,^[39] where patients with university education expressed higher satisfaction levels compared to those with lower levels of education. This may suggest that the healthcare providers in the current study were skilled in tailoring their communication and care delivery to patients of varying educational backgrounds. Furthermore, our research revealed that pre-admission health conditions and prior hospitalizations did not significantly influence patient satisfaction, which is in line with similar findings from Ethiopian patients in Mulugeta et al.^[37] However, these finding contrasts previous studies that suggested that a patient's health status before arriving at the hospital and their previous hospitalization experiences could impact their expectations and, consequently,

their satisfaction with nursing care^[21,39].

Limitations

This study has limitations. It used self-reported data, potentially introducing response bias. The cross-sectional design prevents establishing causality or temporal relationships. Purposive sampling may have introduced selection bias. The study's exclusive focus on nurses in Hail, Saudi Arabia, limits generalizability. However, it's the first study of its kind in Saudi Arabia, contributing to the literature. Reliability and validity tests were conducted, and the study offers valuable insights, calling for further research and targeted interventions in nurse-patient therapeutic communication.

5. CONCLUSION

This comprehensive study on nurse-patient therapeutic communication has identified the importance of three key dimensions—professional, contextual/situational, and patient-related—as significantly influential factors. Additionally, demographic variables such as age, education level, and workplace have been found to have significant effects across all domains. Notably, high patient satisfaction levels were observed, with satisfaction increasing along with patient length of stay. To enhance healthcare delivery, institutions should prioritize the development of comprehensive communication training programs addressing these three critical dimensions. Such programs should equip nurses with the essential skills and heightened awareness necessary to navigate the diverse backgrounds and contexts encountered in patient care. In practice, the implementation of precisely targeted training programs, specifically tailored to different age groups, is imperative. In addition, fostering personalized connections in healthcare settings, including nurses introducing themselves by name and championing a patient-centered approach, can significantly elevate the overall patient experience and amplify satisfaction levels. Moreover, given the positive correlation between patient length of stay and satisfaction levels, healthcare organizations should focus on maintaining consistent, high-quality communication throughout a patient's entire care journey, ensuring that interactions remain patient-centred and nurturing. For future research, it is advisable to delve into age-specific communication training programs tailored for nurses, effectively addressing diverse communication needs irrespective of educational levels.

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The authors have no conflicts of interest to declare.

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