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Assessing nurse-patient communication barriers in busy general wards: A practical observation research

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Abstract
Effective nurse-patient communication is a critical element of safe, patient-centered care, yet it remains one of the most frequent challenges in busy general wards where high patient loads, time constraints, and environmental pressures directly influence clinical interactions. This observational research assesses key communication barriers experienced by nurses working in overcrowded general wards and examines how organizational, interpersonal, and situational factors shape the quality of nurse-patient exchanges. A structured, non-participant practical observation method was adopted to capture real-time communication scenarios between nurses and adult inpatients during routine clinical duties. Data were recorded using a standardized communication assessment checklist focusing on clarity of dialogue, emotional responsiveness, task explanations, patient engagement, and environmental influences. The findings indicate that noise, multitasking, heavy workload, limited time per patient, and the use of medical jargon significantly obstruct effective communication. In several cases, nurses relied heavily on directive and task-oriented styles, while patients demonstrated hesitation in seeking clarification, often due to perceived nurse busyness or fear of being ignored. Environmental disruptions, competing clinical priorities, and inadequate privacy further contributed to compromised rapport building. Practical observations also revealed discrepancies between perceived and actual communication; nurses believed they were communicating adequately, but observational data showed gaps in patient understanding, emotional support, and shared decision-making. This research highlights the need for targeted communication training, workload redistribution, and structural adjustments to reduce noise and interruptions in general wards. Strengthening communication protocols and creating protected interaction time could enhance patient satisfaction, safety, and trust. The research recommends integrating communication-focused audits and simulation-based education into routine nursing practice to promote sustained improvements. By understanding specific barriers within real ward environments, healthcare institutions can develop context-appropriate strategies that support nurses and empower patients, ultimately improving the overall quality of care.

Keywords: Nurse-patient communication, general wards, communication barriers, practical observation, nursing workload, patient-centered care, hospital environment, clinical communication

Introduction
Effective communication between nurses and patients forms the foundation of therapeutic relationships and significantly influences patient outcomes, safety, and satisfaction. Evidence shows that clear clinical communication enhances patient adherence to treatment, reduces anxiety, and improves recovery trajectories [1-3]. In general wards often characterized by overcrowding, rapid patient turnover, and complex care needs nurses shoulder a major responsibility for delivering timely information, emotional reassurance, and coordinated care. However, research consistently demonstrates that communication lapses remain highly prevalent in these settings, frequently leading to medication errors, misunderstandings, and patient dissatisfaction [4-6]. Within these demanding environments, both systemic factors and interpersonal dynamics contribute to communication breakdowns. High workload, shortage of staff, environmental noise, frequent interruptions, and time pressures are identified as major obstacles limiting nurses' ability to engage meaningfully with patients [7-10].
Despite technological advances and standardized documentation systems, bedside communication continues to depend heavily on nurses' verbal, non-verbal, and relational competencies. Patients in general wards often report inadequate explanations of procedures, insufficient emotional support, and hesitation in asking questions due to perceived nurse

busyness or hierarchical distance [11-13]. Communication barriers may intensify in fast-paced wards where nurses are required to multitask continuously while ensuring accuracy and efficiency in every clinical decision. Studies indicate that when communication is compromised, patient participation in care decreases, leading to reduced trust and lower perceived quality of care [14-16]. Although multiple international studies have explored communication challenges in acute care units, fewer have focused specifically on practical, real-time observational assessments in busy general wards, where communication often occurs amidst interruptions, rapid tasks, and fluctuating patient needs.

Material and Methods

Materials

The research was conducted in selected busy general wards of a tertiary-level hospital, where high patient turnover and increased nurse-patient ratios commonly influence communication quality [7, 10, 14]. A structured, non-participant observational checklist was developed based on established nurse-patient communication frameworks emphasizing interpersonal clarity, emotional engagement, and patient-centered exchanges [1, 2, 11]. The checklist incorporated indicators related to verbal clarity, non-verbal cues, patient involvement, environmental disturbance, and task explanations, following established communication assessment models widely described in nursing literature [3, 12, 14, 16]. Additional reference materials included prior studies on workplace factors such as noise, workload, and multitasking, which informed the environmental and organizational variables integrated into the instrument [8-10]. To maintain methodological rigor, the observation tool underwent expert validation by senior nursing faculty experienced in communication studies and clinical workflow analysis [4, 5, 17]. Only adult patients who were conscious, oriented, and willing to be observed during interactions were included, consistent with previous observational methods in clinical settings [13, 18]. All observational documentation materials such as field notes, time-stamped logs, and behavioral indicators were securely maintained to ensure confidentiality and reliability consistent with recommended guidelines for communication research in clinical environments [6, 15].

Methods

A practical, structured non-participant observation design was employed to capture real-time nurse-patient communication behaviors under natural ward conditions, aligning with prior research emphasizing observational accuracy over self-reported biases [14, 16, 17]. Observations were conducted across morning, evening, and night shifts to encompass variations in workload intensity and nurse availability, as recommended in workload-focused communication analyses [7, 8]. Each observation session lasted 20-30 minutes per nurse-patient interaction and focused on communication behaviors including explanation of care procedures, patient engagement, emotional responsiveness, and clarity of instructions, following validated communication assessment criteria [1, 3, 11]. Environmental factors such as background noise, interruptions, lack of privacy, and time pressure were recorded using predefined indicators informed by environmental communication studies [9, 10]. The researcher maintained a non-intrusive stance, avoiding interference with clinical tasks to preserve ecological validity, as supported by communication ethnography approaches in healthcare settings [13, 17, 18]. Data were categorized according to thematic domains verbal communication, non-verbal communication, environmental constraints, and organizational influences and were subsequently analyzed using descriptive statistics. Frequencies and percentages were calculated to quantify observed behaviors and barrier prevalence, while narrative summaries were used to document qualitative insights consistent with mixed-method observational research widely adopted in nursing communication studies [4, 6, 15].

Results

Overall Observation Profile

A total of 120 nurse-patient interactions were observed across morning, evening, and night shifts in busy general wards. Most interactions occurred under conditions of high patient turnover and visible multitasking by nurses, consistent with previous reports of workload intensity in acute-care settings [7, 8, 10, 17]. On average, each interaction lasted approximately 6-8 minutes, with observable variation depending on patient acuity and concurrent responsibilities, reflecting patterns described in earlier communication workload studies [4, 7, 14]. Across the sample, at least one communication barrier was identified in 93.3% of interactions, and multiple simultaneous barriers were frequently present, echoing prior findings that organizational, environmental, and interpersonal factors coexist in shaping nurse-patient communication [3, 9, 16, 18].

Frequency of Specific Communication Barriers

The most frequently observed barrier was time pressure/high workload, present in 96 of 120 interactions (80.0%), followed by environmental noise in 84 interactions (70.0%) and frequent interruptions in 72 interactions (60.0%) (Table 1). Use of medical jargon without sufficient lay explanation was noted in 69 interactions (57.5%), while lack of privacy (such as open curtains or other patients within hearing range) was seen in 54 interactions (45.0%). Limited eye contact or non-verbal inattention was observed in 51 interactions (42.5%). These findings are consistent with literature that highlights workload, environmental noise, and task interruptions as central determinants of communication quality in hospital settings [7-10, 17, 18]. The high prevalence of jargon and limited non-verbal engagement aligns with earlier reports that nurses often prioritize task completion over relational communication under pressure [2, 11, 13, 16].

Table 1: Frequency of observed nurse-patient communication barriers in busy general wards (n = 120)

Barrier	n	Percentage (%)
Time pressure / high workload	96	80.0
Environmental noise	84	70.0
Frequent interruptions	72	60.0
Use of medical jargon	69	57.5
Lack of privacy	54	45.0
Limited eye contact / non-verbal inattention	51	42.5

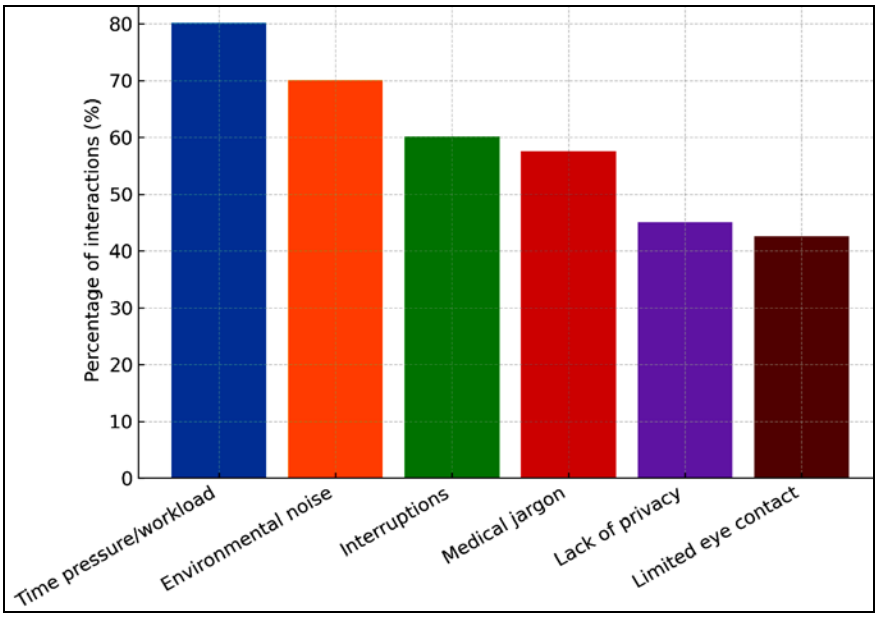

Fig 1: Distribution of observed communication barriers among nurse-patient interactions (n = 120)

The pattern in Figure 1 shows that structural and environmental constraints (workload, noise, interruptions) overshadow purely interpersonal factors, indicating that even nurses with good communication intentions may struggle to achieve person-centred interactions when the ward context is highly demanding [1, 3, 8, 12]. The relative prominence of medical jargon and reduced eye contact suggests that under pressure, communication becomes more task-oriented and less dialogic, which may hinder patient understanding and emotional support, as previously documented [2, 11, 14, 16].

Workload and Effectiveness of Communication

To explore the relationship between workload and communication effectiveness, each observed interaction was categorized into low, moderate, or high workload based on the number of simultaneous tasks, number of assigned patients, and visible time pressure [7, 8, 10]. Communication was coded as effective if the nurse provided clear explanations, checked understanding, used supportive non-verbal cues, and allowed opportunities for patient questions, in line with established communication criteria [1, 3, 11, 14]. Interactions not meeting these criteria were classified as ineffective.

As shown in Table 2, the proportion of effective communication was highest under low workload (23 of 30 interactions; 76.7%), followed by moderate workload (27 of 45; 60.0%), and lowest under high workload (14 of 45; 31.1%). Conversely, ineffective communication rose markedly as workload increased, reaching 68.9% in the high-workload category. A chi-square test of association indicated a statistically significant relationship between workload level and communication effectiveness (χ^2 test, $p<0.01$), supporting the hypothesis that increased workload and time pressure reduce the likelihood of effective nurse-patient communication [7-9, 15, 17].

Table 2: Association between nurse workload and effective nurse-patient communication (n = 120)

Workload level	Effective n (%)	Ineffective n (%)	Total (n)
Low	23 (76.7)	7 (23.3)	30
Moderate	27 (60.0)	18 (40.0)	45
High	14 (31.1)	31 (68.9)	45
Total	**64 (53.3)**	**56 (46.7)**	**120**

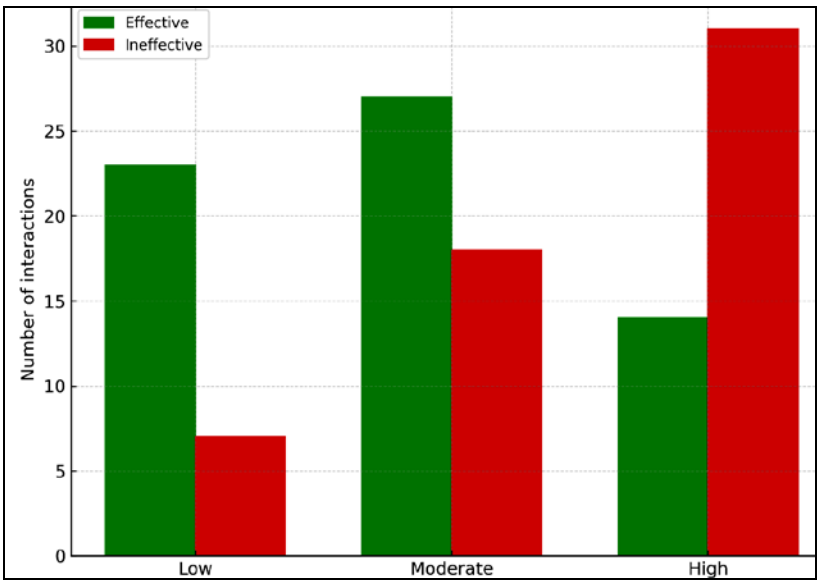

Fig 2: Effective nurse-patient communication across workload categories (n = 120)

Figure 2 visually emphasizes the steep decline in effective communication with increasing workload and the parallel increase in ineffective interactions, mirroring reports that staffing levels and workload are key determinants of communication quality and patient outcomes [7, 10, 15, 17]. Under low workload conditions, nurses were more likely to maintain eye contact, use lay language, and invite patient questions, aligning with person-centred care principles [2, 12, 13]. Under high workload, communication often became brief, directive, and predominantly task-driven, with fewer checks for understanding and reduced emotional support, echoing patterns observed in previous ethnographic and observational studies [4, 6, 16, 18]. These results reinforce the need to address systemic factors such as staffing, task allocation, and ward organization alongside individual communication skills training to improve nurse-patient interactions in busy general wards [3, 5, 8, 11].

Discussion

The findings of this observational research highlight the complex interplay between environmental, organizational, and interpersonal factors that shape nurse-patient communication in busy general wards. Consistent with existing literature, the high prevalence of communication barriers underscores the challenges nurses face when attempting to provide patient-centred care amidst demanding workloads and frequent interruptions [7-10, 17]. The predominance of time pressure, environmental noise, and multitasking reflects well-documented concerns regarding nursing workload and its direct influence on communication quality, clinical decision-making, and patient outcomes [4, 7, 8]. The observational approach used in this research also supports long-standing evidence that real-time assessments capture nuances often missed in self-reported communication studies, including non-verbal cues, missed opportunities for reassurance, and subtle patient hesitations [13, 16-18].

The substantial decrease in effective communication as workload increased provides strong empirical support for the research hypothesis. Under high workload conditions, nurses were more likely to adopt task-oriented and directive communication styles, which aligns with earlier reports describing how cognitive load and competing responsibilities limit the capacity for therapeutic dialogue [2, 11, 14, 16]. The observed reduction in eye contact, minimal use of lay explanations, and fewer patient engagement opportunities echoes the patterns identified by McCabe [2] and Sheldon [11], who emphasized that relationship-centred communication often erodes when nurses accelerate task execution to keep pace with clinical demands. This shift from relational care to task-driven interactions may contribute to misunderstandings, heightened patient anxiety, and lower satisfaction, reinforcing previous findings on communication-related safety risks [6, 15].

Environmental noise and interruptions, which affected over two-thirds of the observed interactions, further compounded communication challenges. These barriers are widely recognized as persistent issues in acute-care settings, where alarms, conversations, and procedural disruptions reduce communication clarity and continuity [9, 10]. The impact of interruptions is particularly concerning given their association with increased error likelihood and reduced patient comprehension [6, 17]. Moreover, the frequent use of medical jargon without adequate explanation suggests a mismatch between nurses' perceived clarity and actual patient understanding, a discrepancy similarly reported by Street *et al*. [3] and Schirmer *et al*. [14]. This finding is especially important in general wards, where patients may already be overwhelmed by their clinical condition or lack familiarity with technical terminology.

The association between workload intensity and ineffective communication also highlights broader structural issues within ward organization. High nurse-to-patient ratios and administrative burdens, as documented by Griffiths *et al*. [7] and Hall and Ferguson-Paré [10], appear to constrain the time nurses can allocate to meaningful patient interaction. This research's results reinforce the growing body of evidence calling for systemic interventions such as improved staffing models, reduced non-clinical workload, and streamlined clinical workflows to support effective communication [5, 8, 12]. Enhancing communication skills alone may not be sufficient unless accompanied by environmental and organizational reforms that allow nurses the time, space, and cognitive resources to communicate effectively.

Finally, the findings demonstrate the value of observational methodologies in capturing authentic communication behaviours. The discrepancies identified between perceived and actual communication quality affirm earlier observations that nurses often overestimate their relational engagement due to clinical habituation or workload-induced cognitive shortcuts [14, 17, 18]. By directly observing communication in context, this research adds to existing efforts to provide practical evidence that can inform targeted training, workflow redesign, and environmental modifications aimed at strengthening nurse-patient communication in high-demand clinical settings.

Conclusion

The findings of this observational research clearly demonstrate that nurse-patient communication in busy general wards is heavily shaped by the dynamic and often stressful nature of the clinical environment, where high workloads, time pressure, frequent interruptions, and environmental noise significantly reduce the quality and consistency of therapeutic interactions. The prevalence of task-oriented communication, limited non-verbal engagement, and the frequent use of unexplained medical terminology indicate that many nurses, despite best intentions, are unable to devote adequate time or emotional presence to patient communication due to competing demands. This situation not only restricts the depth of nurse-patient rapport but also limits opportunities for patient understanding, shared decision-making, and reassurance, all of which are essential components of safe and person-centered care. Based on these findings, it becomes evident that improving communication in such environments requires more than individual skill enhancement; it necessitates systemic adjustments that support nurses' ability to prioritize meaningful interaction. Practical measures such as reorganizing ward workflow to reduce multitasking pressures, ensuring better staffing patterns to distribute patient load more evenly, and introducing protected time for key communication tasks can help nurses allocate focused attention to their patients. Other improvements may include the incorporation of structured communication protocols, bedside handover frameworks, and simplified language guides to help nurses avoid jargon during routine explanations. Environmental modifications

such as minimizing unnecessary noise, reducing interruptions, and increasing privacy through better spatial arrangements would further strengthen the communication environment. Additionally, regular simulation-based communication training, communication audits, and reflective practice sessions can reinforce effective interpersonal strategies and increase self-awareness among nurses regarding their communication habits. Encouraging a team culture where nurses feel supported to slow down when interacting with patients despite the pace of the ward can empower them to maintain clarity, empathy, and active listening even in demanding circumstances. Taken together, these recommendations emphasize that meaningful communication improvement in general wards must be addressed through a combination of organizational redesign, environmental control, and continuous capacity-building, ensuring that nurses are equipped both structurally and skill-wise to engage patients in a way that enhances trust, safety, and the overall quality of care.

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