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EXPERIENCE AND PERCEPTIONS OF NURSES REGARDING THE COMMUNICATION PROCESS WITH PATIENTS

Experiencia y percepción de las enfermeras respecto del proceso de comunicación con los pacientes

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Abstract

Introduction. Nursing practice requires the integration of communication and clinical skills, which results in greater patient satisfaction and improvement in the results obtained, therefore, based on the perceptions and experiences of Primary Care nurses; it is intended to assess communication processes. **Methodology**. To obtain the information required by the study, the in-depth interview has been chosen, the literal transcription allowed the establishment of thematic categories of analysis and the comparison of the results with the literature. **Results.** Communication is perceived very differently by each professional, without a structured method, with a lack of adaptation to the characteristics of each patient, which results in deficits in efficacy, understanding and retention of the message. **Discussion.** Communication problems cause feelings of helplessness and insecurity

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among professionals. The lack of an evaluation of the results, in the process, hinders the possibility of improvement and continuity in care. **Conclusions.** The search for excellence in care requires education and training in terms of communication and continuous evaluation of the results as a guarantee of quality and continuity of care.

Keywords: Nursing, community health services, health centres, communication process, communication users, interpersonal communication, interactive communication.

Resumen

Introducción. La práctica de la enfermería requiere de la integración de las destrezas comunicativas y clínicas, lo que redunda en mayor satisfacción de los pacientes y mejora de los resultados obtenidos, por lo que, a partir de las percepciones y experiencias de las enfermeras de atención primaria, se pretende valorar los procesos de comunicación. **Metodología.** Para la obtención de la información que demanda el estudio, se ha elegido la entrevista en profundidad. La transcripción literal permitió el establecimiento de categorías temáticas de análisis y la comparación de los resultados con la literatura. **Resultados.** La comunicación es percibida de forma muy distinta por cada profesional, sin un método estructurado, con falta de adaptación a las características de cada paciente, lo cual revierte en déficits de eficacia, comprensión y retención del mensaje. **Discusión.** Los problemas de comunicación provocan sentimientos de impotencia e inseguridad entre los profesionales. La falta de una evaluación de los resultados en el proceso dificulta la posibilidad de mejora y continuidad en la atención. **Conclusiones.** La búsqueda de la excelencia de los cuidados requiere una formación y capacitación en términos de comunicación y la evaluación continua de los resultados como garantía de calidad y continuidad del cuidado.

Palabras clave: Enfermería, servicios comunitarios de salud, centros de salud, proceso de comunicación, usuarios de la comunicación, comunicación interpersonal, comunicación interactiva.

1. INTRODUCTION

In healthcare institutions, inadequate communication or its absence between nurses and patients can lead to error-prone situations, resulting in adverse effects or inappropriate treatment. Various nursing associations, including the American Nursing Association (ANA), the American Association of Critical-Care Nurses (AACN), and the General Nursing Council, recognize communication as an essential component of practice standards. They have incorporated this aspect into their respective ethical codes, emphasizing that nurses must act with respect in all professional relationships. These codes also state that nurses should participate in shaping the profession's values through individual and collective action (General Nursing Council, 1989). Both the aforementioned associations and many others across different countries highlight the need to educate nursing professionals in communication concepts and skills, particularly emphasizing the significance of listening as a vital and pivotal element of communication.

AACN (2016) defines communication skills as a "two-way dialogue in which individuals think and decide together," underscoring the necessity for nurses to be excellent communicators, at least on par with their clinical expertise. Organizations that recognize these aspects and provide appropriate avenues for integrating communication and clinical skills develop processes that foster efficient work environments and continuous improvement. According to Laschinger *et al.* (2004), communication should be a facilitating factor in problem-solving, but at times, it doesn't flow as smoothly as it should.

Providing nurses with more information, support, resources, and opportunities can significantly enhance communication among themselves and with their patients. A substantial body of literature addresses this topic, and for this work, we have primarily used references directly linked to the possibility of opening new objectives that allow us to bridge existing gaps in previous knowledge. The works of Knaus *et al.* (1986) were among the first to demonstrate the relationship between coordination levels in an intensive care unit and the effectiveness of care. Since then, inadequate communication is commonly cited as one of the causes underlying various problems related to errors and adverse effects. Therefore, any efforts that influence the improvement of communication skills lead to a positive change in communication processes, patient satisfaction, and outcomes.

2. OBJETIVES

This work aims to assess the processes of healthcare communication between patients and nurses based on the perceptions and experiences of the latter. To achieve this, the communication process during nursing care in a clinical setting will be analyzed from a communicative standpoint, using the nurses' own words. Additionally, the integration of communication into the healthcare process, along with the relevant elements of control and continuous improvement, will be explored. This will facilitate the promotion of effectiveness and the enhancement of communicative competence among healthcare professionals, ultimately serving the best interests of the patients.

3. METHODOLOGY

In-depth interviews were chosen as the primary method for gathering the information required for the study. This qualitative research method involves creating an interview script, which in our case consisted of five questions. These questions were derived from reflecting on the constituent elements of effective communication in the nursing profession within the context of primary care. We referred to certain bibliographical sources that we deemed relevant in this field (Carrió, 2004; Clèries, 2006; Ruiz-Moral, 2004) to shape the interview questions.

The questions were generated based on models by Weiss (1994), Kvale (1996), and Valles (1997), aiming to capture the personal experiences of each interviewee. The questions were framed using the header "From your experience..." and each served a specific research purpose. They were grouped under the thematic category of "agreements and advice" to patients. The questions were listed for use as follows:

From your experience, is it important for the patient to understand the progression and risks of their condition?
From your experience, what methods do you use to convey self-care advice?
From your experience, do you believe that patients comprehend and absorb the information provided during consultations?
From your experience, is it common for patients to make decisions and actively participate in their treatment?
From your experience, how are discrepancies or disagreements with patients resolved? Lastly, do you employ any system to assess the effectiveness of consultations (including your advice and interventions)?

To select the interviewees, contact was established with coordinators from different Primary Care Centers in Valencia and its surroundings. The purpose and objectives of the research were

explained, and permission was sought for conducting interviews through the submission of the project to the Ethics and Research Committee of the area. A qualitative sampling approach in line with the concept of flexible (Marshall and Rossman, 1989) and continuous design (Rubin and Rubin, 1995) was employed, aiming to achieve theoretical saturation (Glasser and Strauss, 2009). The final sample selection was carried out using the "snowball" strategy or technique (Goodman, 1961), where interviewees were asked to refer another person with similar traits, and this process continued until a sufficient number of subjects was attained.

For conducting the interviews, the interviewees' own consultation spaces were chosen. The interviewer visited these places on the specified day and time. Consent for audiovisual recording was obtained at the beginning of each interview, along with consent for the utilization of interview content for research purposes. Interviewees were informed about the anonymization process. "Pilot interviews" were conducted to validate the clarity, appropriateness, and order of the designed questions (Wengraf, 2001) before conducting the final interviews. After transcribing the interviews, the results were organized by thematic categories and compared with the reviewed literature. In a subsequent phase, the transcripts were reviewed, taking into account field notes and visual recording details, to capture emergent ideas during the coding process.

4. RESULTS AND DISCUSSION

The final sample selection was carried out using the "snowball" strategy, as outlined in the methodology. This approach resulted in 21 nurses being interviewed, including four males (19.9%) and seventeen females (80.1%). All participants were informed in advance about the study's purpose and conditions (video recording, duration, data treatment, etc.). Their identities were coded using the letter "E" and their interview order number.

Since the aim was to analyze the importance placed on communication about risks, strategies to facilitate lifestyle changes, and user involvement in their care, the interviews began with the question: "From your experience, is it important for the patient to understand the progression and risks of their condition?" A significant portion of the interviewed nurses acknowledged the importance of patient awareness, but many noted that due to various "conditioning factors," the majority of patients don't grasp, understand, or simply don't want to know about these risks. Some professionals (E9 and E10) even believed that communicating risks to patients was not suitable. Dávila (2018) asserts that claims of professional negligence often stem from inadequate communication about patient risks. When patients don't receive clear and coherent information, they might take inappropriate or unjustified actions, leading to psychological and financial consequences. Ineffective risk communication can also result in physical harm.

There wasn't unanimity among the interviewees regarding the importance and relevance of risk communication to patients. Nevertheless, risk communication, as defined by the World Health Organization (1989), involves "an interactive process of information exchange and coordination of actions between different professionals and communicators to deliver messages about the nature of risk that include population concerns and opinions. This aims to enable the population to make the best possible decisions for their well-being during a risk situation." This process encompasses preparation, monitoring, recovery, and evaluation.

This concept reinforces two central ideas: the need for coordinated actions between researchers, healthcare professionals, and communicators, and the necessity for fluid and timely communication throughout the risk management process. Similarly, on an individual level, the Deontological Code

reminds nurses of their responsibility for health risk prevention—detecting, informing, taking relevant preventive actions, and recording and communicating their interventions.

Cuervo and Aronson (2004) emphasize that information, especially about intervention and treatment effects, is crucial in all healthcare realms and should be communicated to the patient. Some interviewees deemed this important, but with certain conditions. For example, E2 stated, "For some, yes, others don't understand, and sometimes those who care for them aren't even family." E3 considered, "Yes, at least they get a bit scared." E4 suggested that the level of cultural understanding should be considered: "It depends on people's cultural level; many don't understand you." E7 stated, "It depends on each patient, for many, it's not worth telling them because they won't understand or won't listen. They usually take it as a threat." However, E8 believed that "Yes, it's important, but most don't comprehend the extent. They think we always exaggerate; they don't want to face reality. They come because the doctor told them the nurse should monitor them, and that's it." E12 suggested that patients lack commitment, stating that "most of the time, they'd rather not know, to somehow justify their lack of responsibility, you know... diet, exercise, etc." E14 factored in elements like age and overall health: "Based on their age and general state." E15 noted the need to ascertain if the patient and their family were ready "to receive that information." Similarly, "it also depends on the family's opinion." E16 stressed providing information "that the patient can understand and assimilate. Only the risks associated with the conditions we treat, cardiovascular risk, diabetes, obesity." E21 believed that "the patient needs to internalize, they have the knowledge but don't put it into practice, don't make the necessary changes." Furthermore, they expressed that it's desirable for information to focus on practical aspects of the health-disease-care process and for the user to assume an active and collaborative role.

According to Berry (2004), our understanding and behaviors are significantly influenced by how information is presented. In this regard, Ratna (2019) highlights the need for bidirectional intervention methods, which have a greater impact by tailoring information to individual needs and allowing for increased interaction and patient involvement.

In response to the question "What methods do you use to transmit self-care advice?" convergent opinions were observed. The majority of interviewees (13) indicated that advice is primarily conveyed orally, by speaking and repeating information during each visit. Some noted that patients often become confused by the information overload and tend to forget most of what was said during the consultation once they get home. Therefore, they deemed the use of informative pamphlets, visuals, and audiovisual aids important. The way an individual perceives or frames a risk can be significantly influenced by their social situation, experiences of those around them, and their personal biography (Zinn, 2005). None of the interviewees attributed patients' lack of comprehension to their prior knowledge or experiences. However, E7's perspective stands out as they believed, "Each patient needs a different approach, and you have to adapt." E18 emphasized the importance of language choice, reaches patients, E21 proposed that, "The most important thing is for the patient to understand considering the patient's cultural level: "Using simple and clear language appropriate to their education. To ensure information or advice you have to adapt to their cultural level." These latter insights align with what Palací (2008) states about communication being more effective when using routine messages, which both sender and receiver are accustomed to. However, none of the participants employed strategies such as introducing redundancy or using nonverbal language in its various functions: repetition, substitution, accentuation, contradiction, regulation, or complementation, as recommended by Kreps (1995) for enhancing communicative efficiency. Similarly, E6 acknowledged the need for better pedagogical preparation among healthcare professionals to facilitate effective communication. They claimed that the available

media, such as audiovisual aids, are underutilized, expressing, "We don't have many audiovisual resources; we need more pedagogical knowledge. We have computer applications with examples and illustrations, but they're hardly used." E15 recognized some drawbacks in this regard: "Each professional has their own opinions and advice, as well as their way of explaining things, which often confuses the patient. It also depends on each professional's experience."

We must remember that, according to the reviewed literature, professional advice should possess basic characteristics of being concise, personalized, systematic, firm, timely, and motivational. Additionally, according to models of communicative process in healthcare education, two main types of actions together achieve communicative effectiveness: practical demonstrations and feedback. A second model emphasizes a patient-centered attitude, considering both verbal and nonverbal cues, while a third model focuses on motivational interviewing. Building a therapeutic relationship requires the acquisition of active learning skills, empathetic verbal and nonverbal communication, and supportive and convincing behavior, as affirmed by García-Marco *et al.* (2004) and as also deemed necessary by some of the interviewed professionals. Patients need personalized information about their own risks and tend to trust the opinions and information of healthcare professionals with whom they've established an effective and trustworthy relationship (Alaszewski and Horlich-Jones, 2003).

The professional's perspective on the patient's comprehension and assimilation of the received information was assessed through the question: "Based on your experience, do you think the patient comprehends and assimilates the information received during the consultation?" Following this, additional questions were asked about how professionals proceeded to evaluate the results of what the patient had understood, through the question "How do you confirm this?"

From the obtained responses, divergent opinions were observed. Nine interviewees coincided in stating that the majority of patients do not understand or assimilate the information received during the nursing consultation. Some mentioned that learning capacity (E13), age (E1 and E13), and cultural level (E7 and E16) must be considered, necessitating personalized information. Factors like the nurse's professionalism and language choice (E4) and their ability to transmit information (E9) were also mentioned. Some stated that although patients understand the information during the consultation, they easily forget it and need information repeated during subsequent visits (E5, E3, E12). Others believed that patients do understand the information, as mentioned by E3, E6, E7, E10, E16, E19, and E20, but they also added that "they don't follow through with the agreed actions" (E3), or "they struggle" (E11).

In no instance did we observe nurses attributing a patient's lack of understanding to themselves. However, throughout the theoretical work, it's evident that nursing professionals must recognize that interpersonal relationships are a fundamental part of the care process. Therefore, these relationships are integral to the care provided by nursing personnel (Sánchez and Rubio, 2001). The need for communicative skills in nursing professionals (Al-Alawneh *et al.*, 2019) is justified for several reasons, including societal progress, as modern patients wish to be involved in decision-making, a goal that nurses should foster to achieve their primary objectives of self-care promotion, prevention, and health promotion. It's essential that nurses ensure their information and advice are conveyed to patients in a clear and motivational manner. Lastly, but not less important, achieving communicative effectiveness in nursing (Friedemann *et al.*, 2002) fundamentally requires a person-centered approach (Whitehead *et al.*, 2022), considering both personal situations and biological, psychological, social, and spiritual characteristics, which necessitates the acquisition of effective social skills.

Regarding how professionals assess the patient's level of comprehension, diverse opinions emerged. Some agreed that they confirm this by observing "facial expressions" (E8, E16, and E18), whether patients "follow the given instructions" (E2 and E15), whether objectives have been met (E9, E17, E19), "asking the patient about the explanation" (E6, E3, E11), or "analytical results" (E20). Noteworthy is E10's response, asserting that "patients usually understand everything in the consultation, but I don't confirm it." One might wonder on what basis they could make such a claim. Finally, E21 stated that while they believe patients don't understand and assimilate all the information they receive, they find it of utmost importance that professionals don't confirm this. They state: "I don't think anyone evaluates it because we don't realize the importance of what we teach or want to teach."

In this context, the theory of feedback as a communicative factor gains special importance. In this case, the sender—the nurse—must possess the skills to determine whether the feedback resulting from communication is positive or negative, through the patient's attitude and nonverbal and verbal language. For example, observing if the patient remains attentive, nods, reformulates, or correctly repeats the received information during the course of communication constitutes positive feedback. As Shapiro (2004) posits, the true meaning of any communication lies not so much in what the sender intends to convey, but in the effect this communication has on the receiver. Effective patient education doesn't occur unless processes of behavior self-regulation are included (Flórez, 1997).

As previously noted, for message comprehension by the receiver (the patient) to occur, it's fundamental that the sender (the nurse) possesses knowledge of the receiver's personal characteristics, habitual language, abilities, and previous experiences, adapting the message accordingly (Xue-Li *et al.*, 2023). Effective listening occurs when the receiver truly understands the sender's message. For this, Hellriegel *et al.* (2004) suggest guidelines such as the sender's motivation and demonstration of interest, maintaining focus on the message without passing premature judgments, resisting distractions, providing feedback on message comprehension, and summarizing what has been understood.

The subsequent question posed, "Based on your experience, is it common for the patient to make decisions and actively participate in their treatment?" yielded a high degree of convergence in the responses obtained. Virtually all interviewees agreed that it's not common for patients to make decisions about their treatment; most exhibit a passive attitude, expecting nurses to make decisions and communicate possible changes, guidelines, advice, etc. It's worth noting that many emphasized that age, general health, education, and cultural level significantly influence this. In the case of E6, aside from answering the question negatively, they offered an opinion on what they believed should be the case, stating: "I don't think it's common, although I think it should be. Evaluating their preferences, often they aren't asked for much input." According to E13, "this would signify greater patient involvement in their care, but unfortunately, that's not the case. They let themselves be advised and allow us to decide." On a different note, E8 proposed: "It's not very common, but when they do, I let them express themselves, so they can tell me anything at any time, in other words... I treat them as individuals. Just because I'm the professional doesn't mean I'm always right."

As Alfaro-Lefevre (2003) asserts, the Nursing Process has humanistic characteristics that state that as we plan and provide care, we must consider the specific interests, values, and desires of the user (individual, family, or community). The nurse should strive to understand the health problems of each individual and their corresponding impact on the person's perception of well-being and their capacity for daily activities.

The degree of patient participation and involvement in their care is directly proportional to the information received and assimilated. As Davis and Newstrom (1991) affirm, acceptance is a decision made by the message recipient. In this way, the receiver can accept the message to varying degrees (full or partial acceptance) depending on their perception of the message's accuracy, the authority of the sender, and the implications of the message. For this to occur, it's essential for the nurse to adapt their language, expression, and communication methods to the patient's age, overall health, mood, cultural level, etc., so that the patient can contribute their opinions or preferences and actively participate in their care.

Through the following question, we aimed to understand based on the interviewees' experience, how disagreements or discrepancies with the patient are resolved. Several nurses agreed that conflicts are resolved through communication, speaking with patients and trying to make them understand the importance of self-care for their health, as stated by E2, E6, E8, E12, E19, and E21. In some of the responses, a sense of discouragement or mistrust from professionals regarding expected patient outcomes was evident. For instance, E2 noted: "With many of them, the battle is lost; it's hard to change deeply ingrained habits." E3 said: "They spend the entire afternoon on the couch watching TV, no matter how much you stress the importance of short and frequent walks." E10 stated: "The final decision is theirs." E12 expressed: "Often, it's impossible, and you let them have their way." E17: "Sometimes, it's not worth arguing with them."

It was observed that some professionals resort to threats or scolding when facing disagreements or non-compliance with treatment. According to E20, when facing such situations, "You can use the advantage of mentioning it to the doctor so that they tell the patient the same thing; patients tend to listen more to doctors." Among them, E3 stated that: "You scold them, but it doesn't work." E15: "You scare them with what might happen if they don't follow the instructions, warning them about the consequences." E19 reminded patients of the risks they face if they don't take care of themselves. However, some nurses adopted more optimistic stances and employed other strategies. E6 commented: "I try to explain the problem and how we're going to treat it here. I offer alternatives. If they accept, we can negotiate. If not, there's nothing to be done. For example, when a patient says, 'I'm just here to check my blood pressure,' alright, but we need to set some goals through care. Both sides' responsibilities need to be clear." E21 stated: "I'm very positive. I try to make them understand the importance of taking care of themselves rather than just imposing prohibitions. I show them everything they can do and open doors." E7 added a personal touch: "You try to be patient. Every patient is different, and their personal situation must be taken into account. It's important to let them vent, although I admit I get angry a lot, and I shouldn't, but it frustrates me, and I tell them."

Palací (2008) emphasizes the necessity of the sender having prior knowledge of the receiver's characteristics, their usual jargon, and past experiences to ensure correct interpretation of the message and effective communication. When this is not taken into account, he affirms that misinterpretation of the message is highly likely and could be a fundamental cause of discrepancies or non-compliance with treatments and care. This brings us to the theory of the therapeutic relationship and the application of social skills in nursing. Therapeutic communication constitutes a new approach to nursing care and can be defined as a specific type of communication for a helping relationship. The foundation of therapeutic communication is critical and reflective thinking by the professional, placing the patient at the center of the relationship while considering their needs, priorities, difficulties, feelings, abilities, etc. With the patient, a care and work program that aligns with their person and environment should be formed (Chabeli, 2007; Tolosa-Merlos *et al.*, 2023).

For therapeutic communication to be effective, a climate of trust and respect must be established between the nurse and the patient, ensuring confidentiality. Continuity or follow-up should occur through scheduled encounters in which the patient expresses their progress, setbacks, difficulties, etc. The nurse evaluates the potential for progress in education as the established objectives are or aren't resolved in accordance with the plan set by both parties, congratulating and praising achievements and encouraging continued efforts, or altering strategies when necessary.

The subsequent question inquired if any system is used to verify the effectiveness of the consultation (advice and interventions). It hasn't been determined that a specific system or strategy is used to confirm the consultation's effectiveness. This verification typically occurs in the Nursing Care Process (Wolf, 2022) through the evaluation of objective indicators, nursing outcomes measured with scales. Interviewees E2, E7, E10, E19, E20, and E21 affirmed that they verify this through patients' analytical results, blood pressure, and weight in subsequent consultations. Essentially, if results improve, the consultation is considered effective. Only E6 stated that results are confirmed through achieved objectives, saying: "Yes, I usually establish objectives for subsequent consultations. We review and evaluate results or goal attainment with the diary, notes, and constants—weight, etc., based on objective data that I can verify, probing with questions, etc." All interviewees agreed that they don't have sufficient time for this type of evaluation. On the other hand, as E1 pointed out: "You can't know. They do what they want at home."

With the exception of E6's response, all answers to this question indicate a certain lack of knowledge about nursing methodologies and result evaluation processes, and what this implies for effective and efficient care. This is contrary to what the literature suggests and what's established by the Royal Decree 1093/2010, of September 3rd (Official State Gazette, 2010), which approves the minimum set of clinical report data in the National Health System, to be recorded in the nursing care report using active diagnoses, as well as nursing intervention assessments using NIC and nursing outcomes using NOC (Shin *et al.*, 2023). In the same year, through SAS/1729/2010, dated June 17th, the training program for the specialty of family and community nursing was approved and published. This document established the need to assess the updated Service Portfolio and the role that nursing will play in Primary Care, including any activity that promotes user health maintenance, prevention, and improvement.

As Alfaro-Lefevre (2003) asserts, result evaluation, as the final step of the process, is indispensable for checking a person's functional capacity compared to what was expected and targeted as the score on the assessment scale of the indicators of expected objectives or outcomes. This evaluation allows for understanding the patient's progress, the emergence of new issues, and confirmation of the work done. The effectiveness of nursing interventions is assessed through ongoing evaluation, without which, we wouldn't know if the expected objectives or outcomes have been fully achieved, nor if the intervention strategies were suitable or effective, or if changes to nursing interventions and activities are necessary.

In summary, there are disparities between the ideal considerations—such as the need for patients to understand the progression and risks of their condition—and the activities carried out by nursing staff. There are also opportunities for patients to make decisions and actively participate in their treatment. It's imperative for professionals and institutions to recognize this issue and facilitate training processes in nursing methodologies and communication, placing emphasis on evaluation. Simultaneously, developing methodologies that contribute to reducing variability in practice would be beneficial.

5. CONCLUSIONS

The assessment and analysis carried out on the communicative processes between nurses and patients inform us that, to a certain extent, it is not as appropriate as it should be, with a lack of procedures that could have their roots in a lack of training in communication. In our opinion, professionals, in general, are disappointed by the lack of effectiveness and, at the same time, quality in nursing consultations from a communicative perspective. Therefore, we can affirm that while communicative processes are essential, there is a deficit of communication tools and interviewing skills that affect various aspects of their work, and the incorporation of basic nursing care methodologies is necessary. This gives rise to one of the fundamental problems of the current healthcare system: the considerable dissatisfaction that patients have regarding personal relationships and communicative processes with healthcare professionals (Landman *et al.*, 2015; Vidal *et al.*, 2009).

Additionally, there is no consensus observed about the importance of communicating risk to patients; this is perceived very differently from one professional to another. The transmission of professional advice is carried out without a method previously structured based on the characteristics of each patient, which results in deficits in understanding, message retention, and the effectiveness of outcomes. This, in turn, generates a feeling of powerlessness among professionals and highlights the gap between ideals and practice. The lack of result evaluation in the nursing process prevents or hinders the possibility of improvement and continuity in care.

The pursuit of excellence in care requires training and development in communication for professionals, aimed at assessing needs, identifying or uncovering individual desires and preferences, gauging their ability to participate, and maintaining continuous evaluation of outcomes as a guarantee of quality and continuity of care.

The critical, careful, deliberate, and detailed evaluation of various aspects of patient care is key to excellence in healthcare provision. This can make the difference between care practices destined to repeat mistakes and practices that are safe, efficient, and continuously improving. Evaluation provides the necessary feedback to assess patient satisfaction and maximize the value of healthcare provision. To improve, we must consider both the needs and desires or preferences of patients, and to do so, it would be necessary to implement an interactive communication model in nurse-patient communication, as well as the implementation of pre- and ongoing training programs for knowledge and training in social skills and communication strategies for primary care nursing through courses and workshops, with a particular emphasis on developing written and visual materials adapted to patient characteristics. Additionally, it's worth noting that the type of research used both serves as a starting point and a limitation of the study, as although theoretical saturation was achieved, the sample is small and has limited generalizability. Our plan is to expand the research process using quantitative methodologies and patient interviews.

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