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Original Research

Patient's level of perception regarding Nurse-Patient interpersonal relationship at a selected hospital in Gurugram, Haryana

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ABSTRACT:

Background: Nurse–patient interpersonal relationship is a key component of quality nursing care and influences patients' experiences during hospitalization. A positive interpersonal relationship strengthens trust, emotional comfort, and cooperation with treatment, whereas weak interaction may reduce satisfaction and the perceived quality of care. Assessing patients' perception helps identify strengths and gaps in interpersonal care delivered by nurses in hospital settings. **Aim:** To assess the patient's level of perception regarding nurse–patient interpersonal relationship at a selected hospital in Gurugram, Haryana, and to determine the association between perception and selected demographic variables. **Material and Methods:** A quantitative descriptive research design was adopted. The study was conducted in the pulmonary, surgery, and orthopaedic wards of a selected hospital in Gurugram, Haryana, from 28 November 2024 to 15 December 2024. A total of 200 inpatients were planned, and baseline results were presented for 123 participants. Patients aged ≥18 years, conscious, oriented, willing to participate, and able to communicate in English or Hindi were included; critically ill patients, those on anesthesia drugs, mentally unhealthy patients, and OPD patients were excluded. Data were collected using a socio-demographic profile sheet and the standardized 31-item Nursing Care Interpersonal Relationship Questionnaire (NCIRQ). Data were analysed using SPSS version 30 with descriptive statistics (mean, percentage) and inferential statistics (Chi-square test). **Results:** Most patients were aged 18–38 years (39%), male (63%), married (60%), and admitted for surgical diagnosis (67%). Nearly half had illness duration of 1–3 years (47%). High mean scores were observed for trust in procedures (mean=0.92, SD=0.27) and companionship (mean=0.92, SD=0.27). Nurse's touch had the highest mean (mean=4.85, SD=0.47). Lower mean scores were found for family involvement (mean=0.75, SD=0.44) and knowing nurse's name (mean=0.67, SD=0.47). No significant association was found between perception and age, gender, marital status, diagnosis, or duration of illness ($p>0.05$). **Conclusion:** Patients reported overall positive perceptions of nurse–patient interpersonal relationship, particularly regarding trust and supportive nurse behaviors. Limited personalization and family involvement were identified as areas for improvement, and perceptions were not significantly influenced by selected demographic variables.

Keywords: Nurse–patient relationship; Patient perception; Interpersonal communication; Trust; Inpatient nursing care.

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INTRODUCTION

Nurse–patient interpersonal relationship is a central component of nursing practice because it influences how patients experience care, interpret clinical information, and respond emotionally and behaviorally during hospitalization. In inpatient settings, patients often depend on nurses for continuous monitoring, symptom relief, explanations, and reassurance, making the quality of everyday interactions especially meaningful. A therapeutic relationship is more than routine communication; it reflects a purposeful professional connection built through respectful behavior, empathy, responsiveness, and consistent presence, which together help patients feel safe and understood within an unfamiliar environment.[1]Interpersonal relationship in nursing is closely linked with therapeutic communication. Patients frequently judge the quality of care not only

by technical competence but also by how nurses listen, speak, and respond. When communication is clear and patient-friendly, it can reduce fear, support cooperation with treatment, and improve satisfaction with care. Conversely, ineffective communication may lead to confusion, mistrust, dissatisfaction, and reduced willingness to share symptoms or concerns. Evidence from hospital-based studies emphasizes that obstacles such as workload, time limitations, environmental issues, and patient-related factors can interrupt effective nurse–patient communication and weaken the therapeutic connection.[2]Trust is a core feature of nurse–patient interpersonal relationship. In many inpatient situations, patients must accept procedures, medications, and instructions while having limited control over timing and decisions. Patients therefore rely on nurses not only to perform tasks correctly but also to provide explanations and emotional support in a way that feels transparent and respectful. Communication barriers—such as differences in language, limited privacy, cultural discomfort, and hurried interactions—can reduce perceived trust, even when clinical care is appropriate. Research has highlighted that communication difficulties may be perceived by both nurses and patients, suggesting that interpersonal gaps are often mutual and system-related rather than solely patient- or nurse-driven.[3]Patient perception is important because it reflects how care is actually experienced at the bedside. Perception includes how patients interpret nurses' attentiveness, kindness, patience, availability, and willingness to answer questions. These perceptions form a practical indicator of relationship quality and can guide improvement efforts in service delivery. Studies examining inpatient satisfaction with nursing care show that patient perception can vary by setting and context, which indicates that interpersonal relationship is shaped not only by individual nurse behavior but also by staffing, ward culture, workload, and organizational practices.[4]In addition, interpersonal relationship is shaped by the therapeutic intention of nursing care, where communication and caring behaviors are used deliberately to support health and coping. This is especially visible in settings that require longer stays or repeated contact, where patients observe consistency in nurse behavior and develop expectations about how they should be treated. A therapeutic relationship can promote dignity and psychological comfort by recognizing the patient as a person rather than only a diagnosis. Literature discussing the therapeutic relationship emphasizes that relational aspects—such as acceptance, respect, and emotional presence—are fundamental to meaningful nursing care and can influence the overall experience of hospitalization.[5]Caring behaviors form another key dimension of the interpersonal relationship. Caring behaviors include verbal and nonverbal actions such as comforting touch, polite greetings, timely response, empathy, and inclusion in basic decisions. Patients often interpret these actions as signs of genuine concern, which strengthens emotional connection and satisfaction. Empirical work examining caring behaviors and satisfaction indicates that positive interpersonal conduct is associated with better patient evaluations of nursing services, reinforcing that relationship-building behaviors are not separate from clinical care but are part of care quality itself.[6]Assessing patient perception regarding nurse–patient interpersonal relationship is also relevant for quality improvement because patient feedback can highlight which aspects of interaction need strengthening. In different hospital environments, improvements in communication training and supportive supervision have been linked with better patient satisfaction outcomes. Structured communication skill training, for example, is frequently proposed as a practical strategy to enhance interpersonal effectiveness, improve patient understanding, and strengthen the nurse–patient bond. Evidence from intervention-focused research suggests that targeted training can improve patients' satisfaction with nursing staff by improving the clarity and empathy of communication during care encounters.[7]In the Indian healthcare context, where hospitals often serve diverse populations in terms of language, education, and expectations, understanding patients' perception of interpersonal relationship is particularly important. Gurugram, Haryana includes both urban and semi-urban patient groups who may differ in health literacy and comfort in expressing needs. Measuring patient perception helps identify whether interpersonal care is experienced consistently across patient categories and whether relationship-building is strong in practice. A standardized assessment of nurse–patient interpersonal relationship can support evidence-based recommendations for improving trust, empathy, communication, and inclusion of family, thereby strengthening patient-centered nursing care in hospital settings.

MATERIAL AND METHODS

A quantitative descriptive research design was adopted to assess patients' level of perception regarding nurse–patient interpersonal relationship. The study was conducted in a selected hospital in Gurugram, Haryana, and data were collected from the pulmonary, surgery, and orthopaedic wards from 28 November 2024 to 15 December 2024.

Participants, sample size, and sampling technique

The study population comprised patients admitted in the selected hospital in Gurugram, Haryana. A total of 200 inpatients were included based on the calculated sample size. Participants were selected using a purposive sampling technique. Patients aged 18 years or older, willing to provide consent, conscious, oriented, and able to communicate in English or Hindi were included. Patients who were in serious condition,

on anesthesia drugs, mentally unhealthy, or attending outpatient departments were excluded.

Data collection tools and procedure

Data were collected using two tools: a socio-demographic profile sheet and the Nurse–Patient Interpersonal Relationship Questionnaire (NCIRQ). The socio-demographic sheet recorded participant characteristics such as age, gender, education, and occupation. The NCIRQ is a standardized 31-item questionnaire based on Imogene King's theory and assesses components such as communication, trust, and empathy, with established reliability and content validity. After explaining the purpose of the study and obtaining written informed consent, the tools were administered to the participants, and each response session required approximately 15–20 minutes.

Ethical considerations and data analysis

Permission for data collection was obtained from the Chief Nursing Superintendent and Deputy Nursing Superintendent, and approval to conduct the study was secured from the Dean, Faculty of Nursing. Ethical permission was obtained from the concerned departmental authorities of the selected wards. Written informed consent was taken from all participants, and confidentiality and anonymity were maintained throughout the study. Data were analysed using SPSS version 30. Socio-demographic data were analysed using descriptive statistics, and association between patients' level of perception and socio-demographic variables was tested using the chi-square test.

RESULTS

The results presented in **Table 1** describe the baseline demographic characteristics of the 123 patients included in the study. With respect to age, the largest proportion of patients (39%) belonged to the 18–38 years age group, followed by 31% in the 38–58 years group and 25% in the 58–78 years group, while only 5% were above 78 years of age. This indicates that most participants were young to middle-aged adults. Gender distribution showed a male predominance, with 63% males and 37% females. Regarding marital status, the majority of patients were married (60%), whereas 40% were unmarried. In terms of diagnosis, a higher proportion of patients were admitted for surgical conditions (67%) compared to medical conditions (33%). The duration of illness revealed that nearly half of the patients (47%) had been ill for 1–3 years, while 27% had illness for less than one year and 26% for more than three years. Educational status showed that more than half of the patients (52%) had education up to 10th–12th grade, 24% were graduates, and only 8% were illiterate, indicating a relatively moderate level of education among participants.

The findings in **Table 2** highlight patients' perceptions across various domains of nurse–patient interpersonal relationships. High mean scores were observed for trust in procedures and companionship (mean = 0.92, SD = 0.27), indicating strong confidence in nurses' actions and a positive emotional connection between patients and nurses. The highest mean score was noted for nurse's touch (mean = 4.85, SD = 0.47), suggesting that patients highly valued physical reassurance provided by nurses during care. Family involvement in care showed a comparatively lower mean score (mean = 0.75, SD = 0.44), reflecting limited inclusion of family members in the care process. Trust in clinical evaluation by nurses demonstrated a moderate level of perception (mean = 0.71, SD = 0.45). Similarly, knowing the nurse's name had a lower mean score (mean = 0.67, SD = 0.47), indicating limited personalization of care from the patients' perspective.

Table 3 presents the association between selected demographic variables and patients' level of perception regarding nurse–patient interpersonal relationships. The chi-square analysis showed no statistically significant association between perception and age ($\chi^2 = 0.97$, $p = 0.91$), gender ($\chi^2 = 0.00$, $p = 1.00$), marital status ($\chi^2 = 0.85$, $p = 0.65$), diagnosis ($\chi^2 = 0.50$, $p = 0.48$), or duration of illness ($\chi^2 = 1.03$, $p = 0.59$). These findings indicate that patients' perceptions of nurse–patient interpersonal relationships were not influenced by the selected demographic characteristics.

Table 1. Baseline Demographic Data (n = 123)

Details	Categories	Frequency	Percentage (%)
Age	18–38	48	39%
	38–58	38	31%
	58–78	31	25%
	>78	6	5%
Gender	Male	78	63%
	Female	45	37%
Marital Status	Married	74	60%
	Unmarried	49	40%
Diagnosis	Surgical	82	67%
	Medical	41	33%
Duration of illness	< 1 year	33	27%
	1–3 years	58	47%
	> 3 years	32	26%

Educational status	Illiterate	10	8%
	10th–12th Grade	64	52%
	Graduate	29	24%

Table 2. Patient Perceptions Across Various Domains of Nurse–Patient Interpersonal Relationships

Domain	Mean score	Standard deviation	Interpretation
Trust in Procedures (Q28)	0.92	0.27	High confidence in nurses' actions
Companionship	0.92	0.27	Strong emotional connection with nurses
Nurse's touch (Q30)	4.85	0.47	Patients valued physical reassurance
Family involvement (Q24)	0.75	0.44	Limited family inclusion in care
Trust in clinical evaluation	0.71	0.45	Moderate trust in nurses' clinical roles
Knowing Nurse's Name (Q27)	0.67	0.47	Limited personalization of care

Table 3. Association Between Demographic Variables and Perception

Demographic variable	Chi-square	p-value	Significance
Age of the patient	0.97	0.91	Not significant
Gender of the patient	0.00	1.00	Not significant
Marrital status	0.85	0.65	Not significant
Diagnosis	0.50	0.48	Not significant
Duration of illness	1.03	0.59	Not significant

DISCUSSION

In the present study (n=123), most participants were young to middle-aged adults, with **39% in 18–38 years** and a **male predominance (63%)**, and **60% married**; similarly, Achrekar et al. (2020) reported a comparable demographic profile in their communication-focused inpatient survey, where **64% were male** and the largest age group was **46–65 years (50%)**, indicating that hospitalized samples frequently include predominantly male, middle-to-older adult groups depending on the clinical context, while our study included a larger younger adult proportion.[8]

Regarding measurement of nurse–patient interpersonal relationship, our study used a structured interpersonal relationship tool and found **high perceived trust in procedures (mean=0.92, SD=0.27)** and **high companionship (mean=0.92, SD=0.27)**, suggesting strong interactional and communication-related elements from the patient viewpoint; this aligns with the framework of the Nursing Care Interpersonal Relationship Questionnaire described by Borges et al. (2017), which operationalizes interpersonal effectiveness through communication, interaction and role-related indicators and supports interpretive grading of relationship effectiveness using a validated 31-item structure.[9]

A key finding in this study was the **high trust-related perception** (e.g., trust in procedures mean=0.92), which is consistent with evidence that patients often report high trust when nursing care is perceived as reliable; Palaz et al. (2022) similarly reported **high trust in nurses** with a **Trust in Nurses Scale mean of 27.67 ± 3.29** (range 15–30) among hospitalized COVID-19 patients, and also observed a positive relationship between trust and perceived nursing care quality, supporting the interpretation that trust is a central driver of positive patient perceptions of nurse–patient relationships.[10]

In our study, the relatively low score for **knowing the nurse's name (mean=0.67, SD=0.47)** reflects limited personalization despite overall positive relationship domains; a similar concern is reported by Lotfi et al. (2019) in burn wards, where **more than 80% of patients did not know their nurse**, indicating that identification/personalization gaps are common in busy inpatient settings and can persist even when other components of care are perceived positively.[11]

Although our study demonstrated strong companionship and trust-related perceptions, communication remains an important comparator domain when interpreting interpersonal relationship quality; Barilaro et al. (2019) reported that patient satisfaction with nursing communication was strongly linked to perceived communication-related skills, for example, during admission and stay, large patient groups satisfied with nursing explanations/skills were also satisfied with nursing communication (e.g., **972 vs 87**, **849 vs 74**, $p<0.005$), reinforcing that effective informational and relational communication patterns are closely tied to overall positive patient experience—consistent with our high companionship (mean=0.92) and trust-related scores.[12]

Family-related interaction was comparatively weaker in our study (**family involvement mean=0.75, SD=0.44**), suggesting limited inclusion of families in care from the patient perspective; in contrast, Bahmane et al. (2024) found strong stakeholder support for family involvement in an acute assessment unit, with **patients' attitude mean 3.80 ± 0.39 (out of 4)** and measurable preferences for family participation in care activities (patients averaging **5.71 ± 2.16** types of care), indicating that when structures and policies enable participation, patients may report markedly

higher endorsement of family involvement than what was perceived in our setting.[13]

In this study, **no demographic variable** showed a statistically significant association with perception (Age: χ^2=0.97, p=0.91; Gender: χ^2=0.00, p=1.00; Marital status: χ^2=0.85, p=0.65; Diagnosis: χ^2=0.50, p=0.48; Duration of illness: χ^2=1.03, p=0.59), implying that perceptions of nurse–patient interpersonal relationship were relatively uniform across patient subgroups in our sample; however, Kasa et al. (2019) reported differential satisfaction patterns in Ethiopia, with **overall satisfaction 40.7%** and demographic/clinical predictors (e.g., **age group 31–40 years** and employment status associated with lower satisfaction, and ward type influencing satisfaction), suggesting that demographic effects may vary substantially by setting, workload, and care organization even when the same broad construct (patient-perceived nursing care/relationship quality) is assessed.[14]

CONCLUSION

The study concluded that patients admitted in the selected hospital reported overall positive perceptions of nurse–patient interpersonal relationships, especially in trust in procedures and companionship. Nurse's touch was highly valued, showing the importance of reassuring and supportive nursing care. However, limited personalization (knowing the nurse's name) and lower family involvement indicated areas needing improvement. No significant association was found between patients' perceptions and selected demographic variables, suggesting similar perceptions across different patient groups.

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